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In the Military Health System, marketing and education about TRICARE for our active duty and retiree families needs a great deal of attention. This is a never-ending and frustrating battle. Most people are not interested in hearing about their medical benefits until they actually need to use them. Today, our audience is no longer captive. They now have a choice. Beneficiaries may choose to use military services or elect to obtain their health care elsewhere. If military members and families are treated poorly at the military personnel or finance office they may complain; yet, they still must use the military provided services. Customers of MACH may complain if treated poorly, but more importantly, they can take their business elsewhere. It's up to the health marketers to make sure the consumer knows about their health system (Roman, 1996). Marketing may be one of the keys to success in the future. By establishing a strong marketing department, a hospital can capitalize on trends rather than be victimized by them (Naidu, Kleimenhagen, and Pillari, 1992).

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Graduate Program in Healthcare Administration

Development of a TRICARE Marketing Plan for Martin Army Community Hospital

A Graduate Management Project
Submitted to
The Faculty of Baylor University
In Partial Fulfillment of the Requirements of the Degree of
Master of Healthcare Administration

By

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Fort Benning, Georgia
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Abstract

In the Military Health System marketing and education about TRICARE for our active duty and retiree families needs a great deal of attention. This is a never-ending and frustrating battle. Most people are not interested in hearing about their medical benefits until they actually need to use them.

Today, our audience is no longer captive, they have a choice. Beneficiaries may choose to use military services or elect to obtain their health care elsewhere. If military members and families are treated poorly at the military personnel or finance office they may complain; yet, they still must use the military provided services. Customers of MACH may complain if treated poorly, but more importantly they can take their business elsewhere.

It's up to the health care marketers to make sure the consumer knows about their health system (Roman, 1996). Marketing may be one of the keys to success in the future. By establishing a strong marketing department, a hospital can capitalize on trends rather than be victimized by them (Naidu, Kleimenhagen, and Pillari, 1992).

This marketing plan primarily focuses on the MACH staff and those beneficiaries MACH is attempting to enroll in TRICARE Prime with the MTF as their PCM.

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INTRODUCTION

Conditions Which Prompted the Study

Over the past 20 years, healthcare marketing has become an accepted function in the management of healthcare organizations. During this same time, healthcare itself has gone through a dramatic change in reimbursement, competition, and structure (Berkowitz, 1996). When marketing began to be used as a tool in health care, the major purpose of healthcare providers, organizations, and suppliers was to provide the necessary services to deliver care. In a fee-for-service (FFS) environment, more volume was viewed as better for the provider and for the organization since providers and hospitals were reimbursed based on the volume of the service provided. The longer the length of stay, the more money the hospital would receive from the insurance company or the federal government. For the provider, the more diagnostic tests or invasive procedures conducted, the more money the provider would receive. In this FFS environment, the goal of marketing was to generate demand for services. As a result, marketing focused on promotional tools to build awareness of preference for the services of a particular provider (Berkowitz, 1996).

The healthcare industry of the 90's is characterized by massive consolidation among hospitals, physician groups, insurance

entities, and supplies (Berkowitz, 1996). Today's healthcare environment is governed by the concept of efficient deliverance of care. Providers and suppliers must develop strategies within the concept of managing the patient's care in a cost effective manner. In today's environment, necessary services are delivered, but no longer without regard to the cost of such services. Now, hospitals often contract with health insurance plans to provide service for a prepaid amount of money. It is the hospital's responsibility to deliver that quality service in an efficient manner. Physicians also operate in this environment. Most providers today find an increasing proportion of their business accounted for by a managed care arrangement in which they are given a specific amount of money to take care of the healthcare needs of an individual. In this setting, having more volume through longer hospital stays or more diagnostic tests might lead to expending the financial resources allocated before any profit is made.

As a result of the shift in the competitive structure of the healthcare industry, hospitals and health systems are striving to become more market-driven by attempting to identify and satisfy the needs of their customers (Health Care Advisory Board, 1995a). Understanding and quantifying customers' needs and deciding what products and services to provide have also been a major factor in the healthcare marketing movement. Healthcare marketing has

recently spilled into nontraditional arenas, such as the Department of Defense's (DOD) joint service managed care effort.

TRICARE is the DOD's strategy for implementing managed care. The changes TRICARE embodies represent sweeping modification of the $15.7 billion a year Military Health System (MHS) (U.S. GAO, 1998). TRICARE incorporates cost-control features of private sector managed care programs, such as primary care managers (PCM), capitation budgeting, and utilization management in an effort to better serve the 1.6 million active duty and 6.6 million nonactive duty beneficiaries (U.S. GAO, 1998). TRICARE involves awarding regional support contracts to private sector healthcare companies. The TRICARE support contracts are designed to supplement the care available in military medical facilities in the region and provide administrative support. One of the primary administrative support functions entrusted to contractors is the marketing function. TRICARE contractors are responsible for conducting marketing and education programs in the region to include establishing and implementing a marketing plan (DOD, 1998). One can only hypothesize why the decision was made to give this critical piece to the contractor: maybe it was felt the DOD does not possess the necessary marketing expertise or maybe it was determined TRICARE staffs at the military treatment facility (MTF) level could not adequately perform marketing functions due to their many other

duties and responsibilities. Whatever the case, assigning marketing functions to the contractor poses significant risks to the MHS.

Readiness

The military medical organization exists to support combat forces in war and to maintain the well being of the fighting forces during peacetime (U.S. GAO, 1995). By largely abrogating marketing responsibilities to the managed care support contractor, the military medical readiness mission may be vulnerable. In recent years this mission has expanded to include peacekeeping and humanitarian missions. TRICARE places the military in an unfamiliar and unique position of partnering with the contractor, while simultaneously competing. Whether we want to acknowledge it or not, TRICARE is in competition with other healthcare plans that cater to our beneficiary population (TMO Marketeer, 1996). If the contractor does a poor job of marketing the MTF services and patients do not optimally utilize the MTFs, their actions could endanger the future of the MHS. As more patients use contractor provided services instead of MTFs, Congress will undoubtedly question the need for the MTFs and more importantly their personnel. If the DOD slashes the size of its medical force, keeping only enough to carry out wartime requirements, the stability of the TRICARE system would be seriously jeopardized

(Chapman, 1995). A recent DOD study, mandated by the National Defense Authorization Act for fiscal years 1992 and 1993, known as the 733 study, questions the size of the current military healthcare system. The study suggests the DOD has as many as twice the number of physicians it needs to meet wartime requirements (U.S. GAO, 1995). In addition to medical readiness concerns, the proximity of marketing functions to target customers is another important issue.

Locality

TRICARE marketing responsibilities are fragmented across a broad spectrum of organizations with the primary functions resting with each regional contractor. It has been well documented that healthcare is a local endeavor. Marketing of that commodity can best be performed at a local level rather than solely at a regional level. Because health care is a product bought and consumed locally, national marketing strategies won't work in every market (Firshein, 1996). MTF TRICARE staffs are in close proximity to a large segment of their target population and have a similar frame of reference and past experiences. Besides the locality phenomenon, TRICARE appears to be a perplexing issue.

Clarity

At first glance, TRICARE appears confusing and there is misinformation spreading among the beneficiary population (U.S.

GAO, 1998). Many beneficiaries have never had to make decisions about healthcare. If a family member were ill, he/she was taken to an MTF. If the family member lived too far from the installation or if care wasn't available there, the individual was taken to a civilian hospital and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) paid the bill after the deductible was met. It is understandable that some people are lost when it comes to TRICARE. The solution is to enable the beneficiary population by giving them the tools they need to make an informed decision. Dr. Joseph, the former Assistant Secretary of Defense for Health Affairs, contends education is the Achilles' heel and everyone involved must do a better job of educating beneficiaries on the benefits of TRICARE (Joseph, 1996).

It is also unclear if the managed care support contract contains appropriate incentives for the contractor to aggressively market MTF services. Considering these concerns, blindly relying on the support contractor to market TRICARE to the beneficiary population could prove fatal to the MHS. Marketing is now ingrained in the healthcare industry, just as it is in most other industries. In order for military medicine to continue to exist as we know it, it is essential that we, the DOD, proactively market TRICARE, and specifically TRICARE Prime. Time and again, private industry has proven that marketing activities are essential to

product survival and organizational growth (U.S. GAO, 1998). Why should the MHS be an exception?

Statement of the Problem

It is in the best interest of the staff of Martin Army Community Hospital (MACH) to develop their own marketing plan and take an active role in the marketing of TRICARE. Effective marketing will be necessary for TRICARE to be successful and help combat the readiness, locality, and clarity issues. Marketing's presence and influence must be clearly established as critical to the success of the MTF. At the very least, marketing must be an integral component of, and resource for, the change initiative (O'Connell, 1996). Operation without a marketing plan impedes the progress of the entire healthcare organization.

Literature Review

What is Healthcare Marketing?

There are numerous definitions of marketing. Berkowitz defined marketing as "the process of planning and executing the conception, pricing, promotion, and distribution of ideas, goods, and services to create exchanges that satisfy individual and organizational objectives" (Berkowitz, 1996,54). Similarly, Duncan, Ginter, and Swayne offer both a traditional definition and a broader version as it applies to healthcare. Traditionally, "marketing is often defined as an exchange process where customers

buy goods and services and the selling company accomplishes its objectives at a profit" (Duncan, Ginter, and Swayne, 1998). In a broader sense, marketing is a process of providing wanted satisfying goods and services in exchange for value (Duncan, Ginter and Swayne, 1998). The Nursing Times reported marketing is a management process responsible for doing three things: identifying, anticipating and satisfying customer requirements - profitably (Nursing Times, 1993). Griffith states marketing is such an extensive activity that is difficult to develop a uniform definition (Griffith, 1995). As difficult as it is to define, attempting to pinpoint the function in a particular place within an organizational structure can also present a challenge.

The distinction between marketing and management appears to be unraveling, especially as it pertains to the new challenges facing healthcare (MacStravic, 1996). MacStravic concludes that management and marketing have traditionally shared one predominant focus: motivating people to behave in ways they otherwise would not. Table 1 provides three significant distinctions between marketing and management.

Table 1. Management and Marketing Distinctions

Management	Marketing
Internal targets	External targets
Relies primarily on authority to change behavior	Relies on creating rewarding exchanges of value to change behavior
Aims to achieve 100 percent response	Hopes for a significant response

(MacStravic, 1996)

Duncan, Ginter, and Swayne state marketing is an element of strategic planning (Duncan, Ginter, and Swayne, 1998). Griffith similarly claimed marketing incorporates all of what is described as planning and marketing (Griffith, 1995). Today, because of these fading lines, hospital administrators are in the process of merging the two previously autonomous positions of marketing analyst and strategic planner into a consolidated function often referred to as strategic marketer (Duncan, Ginter, and Swayne, 1998). The bottom line is that marketing is no longer seen as an isolated activity. While it is difficult to define and place marketing, the central theme of customer focus and satisfaction aids in understanding the background of healthcare marketing.

Evolution of Healthcare Marketing

The marketing function has gone through many phases since it emerged as a mainstream business practice. Near the turn of the century, a time when the United States was seeing great innovation and inventions, such as the automobile, the business community

focused on product development. Creative thinkers were employed to make judgments about what they thought customers might want, and then tasked to create products that fit the bill. This "production orientation" was characteristic of marketing until the introduction of mass production technologies in 1920 (Berkowitz, 1996).

With the popularity of mass production in the 1920s, economies of scale became the focus of management and the marketing effort. By selling in greater volume, producers of goods and services could sell their wares cheaper. Although this "production orientation" is still employed in many businesses, such organizations are finding themselves increasingly criticized for alienation by both employees and customers through their attempts to become streamlined and highly efficient. Attacks on this mindset are evident in many current commercial advertisements. Both manufacturing and service industries are now trying to present an image of specialized service and customer oriented business.

In healthcare specifically, marketing received great stimulus in the 1980's as pressures for cost control caused revenues to be threatened (Griffith, 1995). Marketing has become one more dimension of doing business in the 1990's healthcare market place for both providers and insurers. It is difficult to build a practice these days without a sophisticated marketing effort (The Physician's Advisory, 1996). The massive marketing efforts by

health plans and hospital systems across the country make it easy to generalize those statements for the entire healthcare industry. The bottom line is there is a reasonable amount of evidence which suggests marketing works in the healthcare industry consistent with the vision of the proponents (Naidu, Kleimenhagen, and Pillari, 1992). Based on the conclusion that healthcare marketing is essential to survive in the marketplace, understanding where it is heading is also consequential.

Healthcare Marketing Trends

As a result of growing competition, clinical outcome studies have become critical in healthcare marketing as managed care customers demand documentation to prove quality. This proof may allow health service organizations to command a premium in contract negotiations (Physician's Marketing and Management, 1996a). Jaklevic validates this; as prices stabilize, purchasers will pay closer attention to quality. Report cards are one way to convey the quality message and hospitals are now publishing their own report cards. These report cards vary widely in presentation style, types of data offered, and target readership, but they are all meant to feed increasing consumer demands for accountability (Jaklevic, 1995). Hospitals are also using patient satisfaction information for marketing purposes (Health Care Advisory Board,

1994b). While outcomes, quality, and patient satisfaction impact healthcare marketing efforts, other trends also prevail.

Capko and Anwar claim that with effective marketing you can succeed in a competitive, managed care environment (Capko and Anwar, 1996). The Health Care Advisory Board believes marketing should be treated as an investment, which should be tracked, measured, and evaluated for reasonable returns (Health Care Advisory Board, 1995b). Another notable trend is the decline in marketing budgets. Between 1993 and 1994 the average hospital marketing expenditure fell 3.3 percent (Health Care Advisory Board, 1995b). The personal selling of healthcare services will grow in importance in the future (Naidu, Cooper, and Reinhart, 1992). Prevention and wellness will become a very popular marketing scheme for general physicians and internists, as it has been for managed care organizations and giant hospitals (Profiles, 1996c). Consumer-oriented marketing is sparking debate.

Surprisingly, the Health Care Advisory Board believes consumer-oriented healthcare marketing will disappear as overall managed care penetration increases. Hospitals' and health systems' marketing departments will be forced to apply their expertise to attracting physicians and managed care contracts, rather than marketing directly to consumers (Health Care Advisory Board, 1994b). They also believe traditional marketing media, such as

radio, television, and newspapers will be replaced by forums such as direct mailings and billboards, targeted to specific markets (Health Care Advisory Board, 1995a). Further stated, although current marketing trends indicate hospitals are spending less time on consumer-directed programs and more time marketing to payers and employers, all of the sources contacted for this report noted that underestimating the importance of the consumer is a fatal flaw (Health Care Advisory Board, 1994b). Upton agreed when he stated the consumer voice is an emerging power, particularly in the managed care context (Upton, 1995). Even the mechanisms used for healthcare marketing are changing.

There are tools which will become more important in the successful marketing of healthcare. Medicine on the Net claims the World Wide Web is an ideal outlet to market healthcare services (Medicine on the Net, 1996). Healthcare marketers are now also using information systems for planning prevention campaigns and new health services, analyzing health factors and disease incidence, determining where to target market, or even for setting up a physician network (Capitation Management Report, 1995). The scope of healthcare marketing is also expanding into previously uncharted areas.

In the past, most marketing professionals have stayed clear of the subject of holistic care; this is no longer the case. Holistic

care is the treatment of the mind, body, and spirit simultaneously. "Holistic care is placing a new and often unique challenge on medical marketing professionals, taking them into an arena which medicine has deemed taboo for generations" (Stacy C. Johnson, personal communication, October 28, 1998)". MacStravic provides another trend. Instead of pursuing vertical integration, hospitals might better use their capital by seeking value-added partnerships with their suppliers. These types of relationships aim to create a mutually beneficial effort. Other industries have used this approach to improve quality and reduce costs; why not healthcare (MacStravic, 1993).

TRICARE

During the last several years, the United States has participated in spirited debate over healthcare issues. At the center of this debate is the issue of providing quality healthcare without breaking the bank (U.S. GAO, 1998). In the 1980's, MHS costs rose more than that of the nation, 225 and 166 percent, respectively. The greatest portion of growth occurred in the CHAMPUS program, which grew by about 350 percent during this period. The medical portion of the Defense budget doubled, from 3 to 6 percent of the total in the same period (U.S. GAO, 1995). The chief drivers of the cost growth were a growing military beneficiary population that made greater use of healthcare services

than its civilian counterparts and a system of resource allocation that encouraged managers to increase hospital workload (U.S. GAO, 1995). Those cost issues, coupled with the so-called peace dividend -- the closure of military bases and military drawdown, prompted the military to look for new avenues to deliver healthcare. TRICARE is the DOD's response to this challenge.

TRICARE is accomplished through a military partnership with civilian contractors. For each of 12 regions of the country, a military Lead Agent will be responsible for overseeing the program. Before this transition to managed care, the MHS consisted of military hospitals and clinics supplemented by CHAMPUS insurance. CHAMPUS is comparable to private-sector indemnity health plans. Beneficiaries pay for care up to an annual deductible amount, and then pay a portion of the remaining costs; however, they do not pay premiums. This system lacked sufficient incentives and tools to control expenditures, did not provide beneficiaries accessible care, and suffered from frequent and large CHAMPUS cost overruns. Congress authorized numerous demonstrations of alternative healthcare delivery approaches to reverse those trends. DOD's experience with these initiatives culminated in the decision to implement TRICARE (U.S. GAO, 1996). That explains why parts of TRICARE might look familiar, as managed care elements were pulled from Catchment Area Management (CAM) tests, CHAMPUS Reform

Initiative (CRI) tests, the Healthcare Finder program, and the Partnership program (Seignious, 1996). CAM made individual MTF commanders responsible for managing care in their area and held them accountable for all funds spent (U.S. GAO, 1995). In contrast, CRI took the CHAMPUS dollars and hired a contractor to perform all the services outside the MTF walls. Dr. Joseph, former Assistant Secretary of Defense for Health Affairs, stated the seeds of TRICARE were planted a few years ago with the CHAMPUS Reform Initiative (Joseph, 1996). TRICARE moves the MHS from a fee-for-service system to a managed care system. The intent of Congress is that TRICARE must not increase DOD's healthcare costs (U.S. GAO, 1996). TRICARE is a medical program for active duty members, CHAMPUS eligible family members, non-Medicare eligible retirees and their family members, and survivors of all uniformed services. It offers nationally guaranteed benefits (outpatient care, inpatient care, prescription drugs, radiology, laboratory, mental health, drug counseling, and preventive care) plus additional services offered through CHAMPUS and MTFs (Seignious, 1996). It is important to note that TRICARE does not replace CHAMPUS, but it more closely integrates the direct care system and CHAMPUS. TRICARE is intended to ensure a high-quality, customer-focused, consistent healthcare benefit; preserve choice of healthcare providers; improve access to care; contain healthcare costs for

patients and taxpayers alike; and maintain medical readiness for all contingency operations (U.S. GAO, 1998).

TRICARE offers beneficiaries three choices for their healthcare: TRICARE Standard, a fee-for-service option which is the same as CHAMPUS; TRICARE Extra, a preferred provider option, and TRICARE Prime, an HMO-like alternative that provides comprehensive medical care to beneficiaries through an integrated network of military and contracted civilian providers. As individuals migrate from Standard to Extra to Prime, out of pocket beneficiary costs decrease, as does freedom of choice. Enrollment is only required for TRICARE Prime and is accomplished for one year. Enrollment is mandatory for active duty personnel and optional for other CHAMPUS beneficiaries. There are no enrollment fees for active duty families, while retirees and their families are required to pay annual enrollment fees. TRICARE Extra and Standard are accessed through a TRICARE Service Center, which offers a Health Benefits Advisor and Healthcare Finder. TRICARE Prime is the focal point of TRICARE.

Each person who enrolls in TRICARE Prime has either a military or civilian PCM. This gatekeeper supervises care, to include authorizing referrals for specialty care. All active duty service members are enrolled in Prime and will continue to receive most of their care from military medical personnel (What is TRICARE, 1997).

A point-of-service option is available under TRICARE Prime. Other than active duty, enrollees may obtain care outside the provider network, but cost sharing requirements under this option are much higher (TRICARE Policy Guidelines, 1996). TRICARE Prime also has access standards that apply whether a military or civilian provider provides treatment. Those who elect not to enroll in TRICARE Prime may still obtain care at MTFs on a space available basis. Unfortunately, TRICARE, coupled with the effects of base closures and downsizing, may push non-enrollees entirely out of the military healthcare system (U.S. GAO, 1996). The support contracts are an important piece of the TRICARE puzzle.

The contracts are bid on a competitive basis and considered fixed-price, at-risk contracts. However, only the administrative portion of the contract has a fixed price, while the healthcare price is subject to adjustments on the basis of risk sharing provisions in which the contractor and the government share contractor losses and gains beyond a certain level. Price adjustments can be based on factors such as inflation, beneficiary population, and military treatment facility usage. The risk sharing and bid price adjustment features are intended to protect both the contractor and the government from the large risks associated with these complex contracts (U.S. GAO, 1995). The primary functions of the TRICARE Support contractor are:

- Development of civilian provider networks in support of both TRICARE Prime and TRICARE Extra benefits
- Claims processing and data collections
- Utilization management and quality assurance
- Patient routing, referral, and beneficiary services
- TRICARE Prime program enrollment
- Provider and beneficiary education
- Marketing

The TRICARE support contracts are procured centrally by the Office of the Civilian Health and Medical Program for the Uniformed Services (OCHAMPUS) (TRICARE Policy Guidelines, 1996). The DOD estimates these contracts will cost about $17 billion over the 5-year contract period (U.S. GAO, 1996).

The medical readiness piece cannot be forgotten. Dr. Joseph believes most tend to think of TRICARE in terms of the everyday responsibilities of providing care for patients, operating from fixed facilities, and having capabilities supplemented by managed care support contractors. TRICARE is more than that because it also includes important aspects of the readiness mission. He claims the change offers DOD the ability to retain military medicine (Joseph, 1996). Others have similarly stated TRICARE's success will allow the military to continue preparing for the readiness mission (Whittington, 1996). This preparation is to be

accomplished by having a flexible healthcare system, readily adaptable to the vastly changing operational missions (Joseph, 1996). Only time will tell if the readiness component is adequately addressed in TRICARE. TRICARE is an ambitious program and it does have skeptics.

Just weeks before retiring as The Surgeon General of the Army, Lieutenant General LaNoue openly criticized TRICARE, claiming corporate profits are put ahead of high-quality care (Willis and Matthews, 1996). The General Accounting Office has also provided a laundry list of concerns related to TRICARE (U.S. GAO, 1995):

- Several studies suggest more cost-effective ways to provide or arrange for healthcare services, such as the Federal Employees Health Benefits Program.
- The regional structure does not provide sufficient authority and control over resources.
- The procurement process is cumbersome and contentious.
- Beneficiary groups are concerned the DOD will impose limits on enrollment in the HMO option, reducing access to MTFs for retirees and their family members.
- True uniformity in benefits and cost saving have yet to be achieved, and some inequities still remain because not all beneficiaries will have access to all three options because medical resources vary by location.

- An attractive benefit such as TRICARE may entice more people than the system can cost effectively accommodate, which could result in increased overall healthcare cost.
- The absence of universal enrollment makes it unlikely TRICARE will achieve its maximum efficiency.

TRICARE MARKETING

The TRICARE Marketing Office (TMO) is the bedrock of the TRICARE Marketing effort. DOD Health Affairs (HA), in concert with the services' Surgeons General, created the TMO. The TMOs mission is to research, prepare, and coordinate the implementation of the DOD program to educate and inform all military medical beneficiaries and providers regarding all aspects of TRICARE. This office acts as the public affairs and marketing liaison for the DOD with all the DOD services, the Coast Guard, the Public Health Service, the Department of Veterans Affairs, and the TRICARE Support Office (DOD, 1998). The TMO prepared an overall marketing plan that describes the situation, provides a marketing strategy, defines objectives, details roles and responsibilities, and provides an action plan. The DOD TRICARE Marketing Plan lists additional roles and responsibilities for many DOD organizational elements. These roles and responsibilities will be addressed in the Action Plan and Responsibilities section of this document.

Purpose

The purpose of this Graduate Management Project is to develop a TRICARE Marketing Plan for MACH which will build positive exchange relationships with the active duty and beneficiary populations. Such a plan does not currently exist and healthcare delivery under TRICARE has been in effect since July 1996. A working hypothesis is not provided since the project is a marketing plan, not a study per se. Variables will be identified when conducting research of the plan.

METHODS AND PROCEDURES

This is a "Product" GMP that will result in a TRICARE Marketing Plan for the Martin Army MHS Catchment Area. There is no cookbook recipe or magic formula for accomplishing a marketing plan. Common components of a marketing plan typically include an internal assessment, external assessment, objectives, strategies, and tactics. Table 2 depicts the marketing plan outline offered by Berkowitz (1996) in Essentials of Health Care Marketing and provides an excellent template to capture these components and will be followed for the MACH Catchment Area TRICARE Marketing Plan.

Table 2. Marketing Plan Outline

I	Management Summary
II	Economic Projections
III	The Market - Qualitative
IV	The Market - Quantitative
V	Trend Analysis
VI	Competition
VII	Problems and Opportunities
VIII	Objectives and Goals
IX	Action Programs

(Berkowitz, 1996)

Validity and reliability will not be addressed, since this is a marketing plan, not a traditional study.

Management Summary

We have flunked Marketing 101 (Roadman, 1997). The Air Force (AF) Surgeon General, at the American College of Healthcare Executives (ACHE) delivered that blunt statement in March of 1997. The former United States Air Force (USAF) Chief of Staff, General Fogleman, has made similar comments. Marketing and education about TRICARE for our active duty and retiree families needs a great deal of attention. This is a never-ending and frustrating battle. Most people are not interested in hearing about their medical benefits until they actually need to use them. This marketing effort needs to be an ongoing process geared toward each audience; not just military families, but health care providers and medical leaders at all levels (Fogleman, 1997).

The stage has been set. The vision statement for the Military Health System (MHS) is as follows. An enterprise providing health support for the Nation's security, the MHS:

- Fields a uniquely trained, equipped, and qualified team to meet the health needs of the fighting forces anytime, anywhere.
- Projects military health forces worldwide to advance our national security interests.
- Promotes a model health system valued by commanders, and all others we serve.
- Functions as an integrated and accountable health team.
- Develops leaders through continuous individual and organizational learning.
- Takes advantage of research and technology to advance health and readiness.
- Promotes health through the best practices of prevention and intervention.

This TRICARE Marketing Plan for the Martin Army Community Hospital (MACH) MHS Catchment Area supports that vision. Military Treatment Facilities (MTFs) are no longer like the post personnel or finance office. MTF personnel cannot frame and hang statements on the wall which claim how important the customer is and expect that to be enough. Our audience is no longer captive, they have a

choice. Beneficiaries may choose to use military services or elect to obtain their health care elsewhere. If military members and families are treated poorly at the military personnel or finance office they may complain; yet, they still must use the military provided services. Customers of MACH may complain if treated poorly, but more importantly they can take their business elsewhere.

It's up to the health care marketers to make sure the consumer knows about their health system (Roman, 1996). Marketing may be one of the keys to success in the future. The role of marketing will emerge as the main driving force behind successful health care facilities (Naidu, Kleimenhagen, and Pillari, 1992). By establishing a strong marketing department, a hospital can capitalize on trends rather than be victimized by them (Naidu, Kleimenhagen, and Pillari, 1992). With effective marketing, you can succeed in a competitive, managed care environment (Capko and Anwar, 1996).

As the MHS moves from a fee-for-service, workload based health care delivery model to a managed care model, marketing will become increasingly more important. Under TRICARE, large amounts of marketing responsibilities are passed to the MCSC.

Couple that with projected changes to incentives that make it crucial that individual MTFs, such as MACH have a marketing plan

designed to attract and maintain significant TRICARE Prime enrollment. Table 3 shows the target population MACH will have to attract in order to be successful. The target population is simply the total catchment area population, less active duty, guard, reserves, and Medicare eligible beneficiaries (because those beneficiaries are not eligible for TRICARE).

Table 3. MACH Catchment Area Target Population

	1997	1998	1999	2000
Catchment Area Population	76,785	77,492	69,943	70,560
Active Duty	20,584	20,346	15,281	15,275
Guard & Reserve	430	2,294	345	346
Females 65 +	4,684	4,804	5,293	5,509
Males 65 +	4,006	4,161	4,619	4,740
TARGET POP	47,081	45,887	44,405	44,690

(Source: Naval Medical Logistics Command, 1999)

This document is not static; it is ever changing. This marketing plan primarily focuses on the MACH staff and those beneficiaries MACH is attempting to enroll in TRICARE Prime with the MTF as their PCM. This marketing plan is for the three year time period beginning in June of 1999 and ending in May of 2002. While the current focus is on TRICARE Prime enrollment, methods to recapture TRICARE Extra and Standard use will be added at a later date. Readers are encouraged to build on these ideas to suggest better methods to achieve the objectives.

Economic Projections

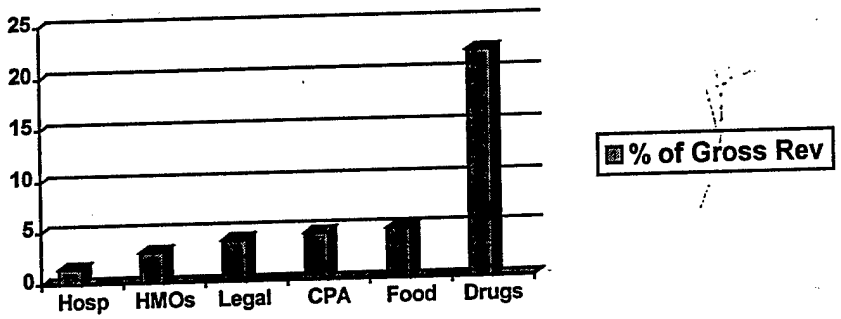
DOD's ability to contain health care costs as it transitions from CHAMPUS to TRICARE contributed to a smaller budget request for fiscal 1997. At $9.4 billion, the Defense Health Program (DHP) is down from $9.8 billion in fiscal 1997 (Gillert, 1996). The overall DHP costs approximately $15 billion each year, including military personnel costs. As a general rule of thumb, 50 percent of the MHS budget is military personnel costs, 25 percent TRICARE (Civilian Health and Medical Program of the Uniformed Services or CHAMPUS equivalent) and the other 25 percent direct care/operations and maintenance (O&M) (Roadman, 1997).

The Fiscal Year (FY) 1999 budget for MACH is 50 million (Stephen Wallace, personal communication, March 28, 1999). Budget numbers are not available for FY 00, 01, and 02; however, the budget is expected to be significantly less. Anecdotal numbers being discussed indicate a 4 to 5 percent budget reduction is likely. This reduction is to be "paid for" or offset through reduced utilization.

MACH does not identify marketing as a specific budget line item. Currently, marketing expenditures are rolled up in the Clinical Support Divisions (CSDs) operating budget, since CSD is currently responsible for the marketing function. Marketing practices require a heavy investment of time, money, and human

resources Ling, Franklin, Lindsteadt, & Gearon, 1992). The biggest investment this plan requires is that of staff members' time. Other expenses include reproduction expenses, mailing expenses, and training requirements. If another staff member is required, the expense would be the salary of a GS-5 or GS-7, plus their benefits. Even in the civilian sector, hospitals typically spend less on marketing than most other organization, as depicted in Figure 1.

Figure 1. **Percent of Gross Revenues Spent on Marketing**



(Source: Health Care Advisory Board, 1996)

Further, research suggests that health systems spend approximately one percent of gross revenues on marketing (Health Care Advisory Board, 1996).

The Market - Qualitative

Resources

Martin Army Community Hospital is a large 240-bed community hospital that provides inpatient and outpatient medical support to Department of Defense (DOD) eligible beneficiaries within its

assigned catchment area and many others in parts of Georgia, Florida and Alabama. Fort Benning, Georgia, Home of the Infantry, is a U.S. Army Training and Doctrine Command (TRADOC) post. The primary activity of the installation is the U.S. Army Infantry School, which teaches 23 different courses to both officers and enlisted soldiers.

The hospital, named in honor of the late Major General Joseph I. Martin, MC, was opened on 8 April, 1958, at a cost of slightly over $6 million for the initial construction. The nine-story building includes sophisticated surgical capabilities, laboratory, radiology, pharmacy, and other ancillary support facilities. Some 1200 civilian and military staff members provide inpatient care to 33 patients daily and over 1,200 daily outpatient visits.

Realizing the need to provide health care facilities to meet the growth of Fort Benning and the increasing ambulatory care demands, a 59,000 square foot Ambulatory Patient Clinic Wing was constructed at a cost of $3.8 million. In order to support the purchase of modern medical equipment and to ensure the compliance with JCHAO standards, an extensive electromechanical upgrade project was completed during the 1976-1980 time frame.

MACH is responsible for the operation of several facilities external to the main hospital. Eight Troop Medical Clinics and four Family Practice Clinics support training activities on the

Fort Benning installation and two additional Troop Medical Clinics are located at Dahlonega, Georgia and Eglin Air Force Base, Florida, in support of the Ranger training program. Also, external to the main hospital are the Alcohol and Drug Abuse Prevention and Control Program, Physical Examination Service, Social Work Service, Community Mental Health Service, Preventive Medicine Service, Veterinary Service, and the Noble Army health clinic in Alabama.

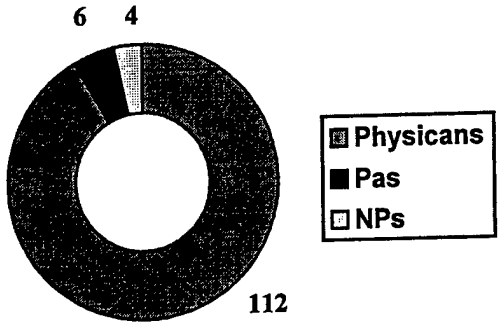
The Army Medical Department's initial family Practice Residency Program was established at Martin Army Community Hospital in 1972. Currently 28 residents are enrolled in this teaching program which provides care to over 18,000 patients. Other specialty training programs include a residency in Health Care Administration, Phase II training for several enlisted specialties and numerous clinical rotations or internships conducted in cooperation with local educational institutions.

In order to keep pace and to better meet the future demands and expectations of our patients, MACH has renovations funded for the Emergency Room, and Acute Care Clinic, and a Woman's Health Center.

Staffing consists of 1215 full time equivalents, 122 of which are providers. Figure 2 shows the providers by profession.

Figure 2.

Martin Army Community Hospital Provider Authorizations FY 98
122 Total Providers



(Source: Wallace, 1999)

As of April, 1999 there are 112 assigned to the hospital. Table 4 lists those assigned physicians by specialty.

Table 4. Physicians Currently Assigned

41	Family Practitioners
7	Internist
2	Flight Surgeons
3	Psychiatrists
4	Surgeons
5	Obstetricians
2	Administrative Positions*
1	Preventive Medicine
2	Urologist
2	Dermatologist
1	Allergist
2	Anesthesiologist
2	Orthodontist
1	Ear, Nose, and Throat
1	Child Psychiatrist
1	Neurologist
6	Ophthalmology
1	Field Surgeon
9	Radiologist
3	Pathologist
6	Emergency Room
4	GMOs
6	Pediatricians

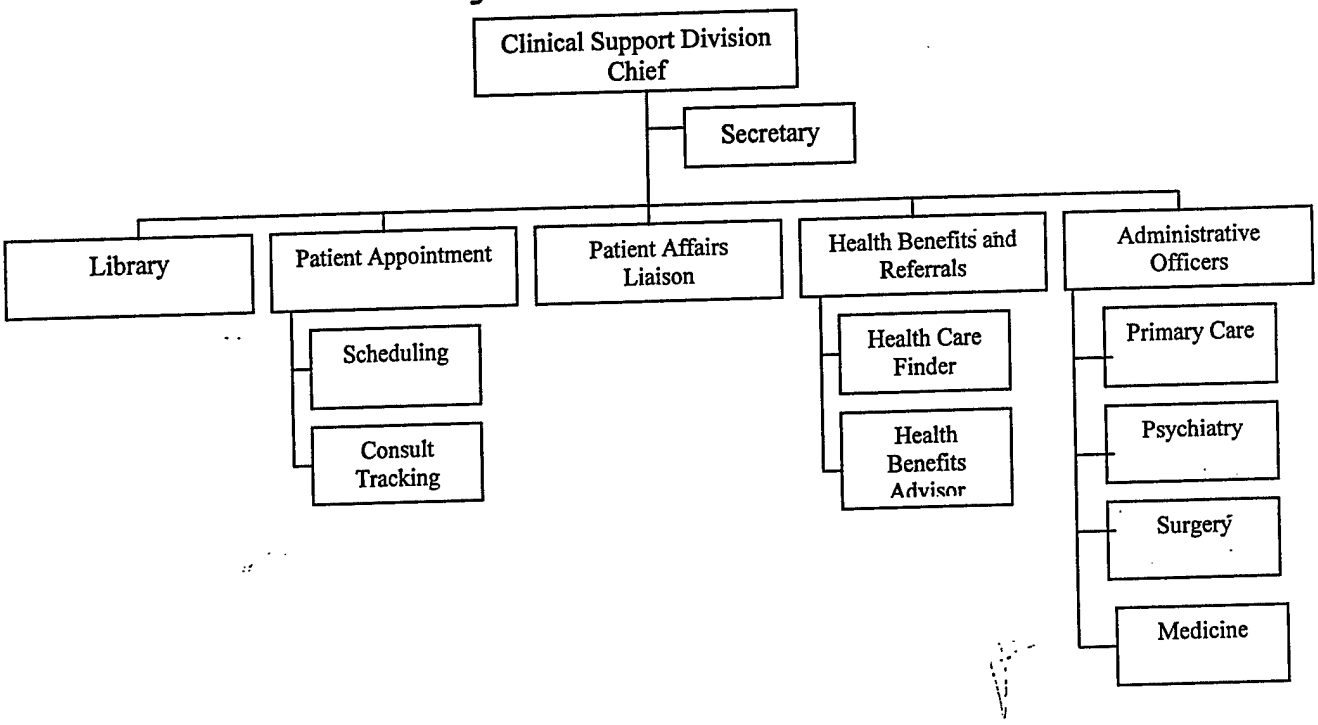
(Source: Wallace,1999)

* Positions normally considered administrative in nature: Hospital Commander, and the Deputy Commander for Clinical Services

As of April 1999 CSD consisted of a staff of 23 members. The CSD organizational chart is provided at Figure 3.

Figure 3.

Clinical Support Division Organizational Chart



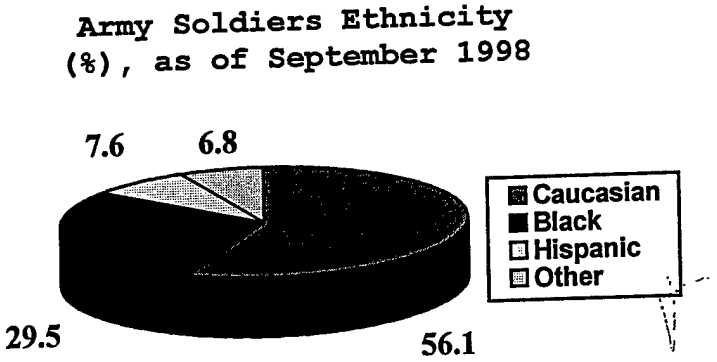
Customers

MACH defines customers as beneficiaries who use their services either exclusively or on a contingent basis. This definition also includes the Post Commander and the hospital staff. The assigned catchment area population consists of approximately 72,000 eligible beneficiaries (Naval Medical Logistics Command, 1999).

Active duty service members assigned to MACH are automatically enrolled at the MTF, which serves as their gatekeeper. Therefore, an understanding of service members as a whole is beneficial. As of September 1998, the Army consisted of 483,880 soldiers (78,060 officer and 405,820 enlisted). The

average officer is 33 years old, while the average enlisted person is 26. Roughly one-third of the force is below the age of 26. Only 14.8 percent of the active force are women (HQDA, 1998). The Army is not as ethnically diverse as one might expect, as Figure 4 demonstrates.

Figure 4.



Based on a population of 483,880

(Source: HQDA, 1998)

Almost two-thirds of the force is married and they support 720,419 family members.

Army soldiers, in general, are fairly well educated with 33.2 percent of officers possessing advanced or professional degrees, 95.7 percent of the enlisted force have a high school education. Additionally, 27.7 percent of enlisted personnel completed at least some semester hours towards a college degree (HQDA, 1998).

MACH's assigned catchment area consists of a 40-mile radius in Georgia and Alabama. It includes the southwestern portion of

Georgia and the southeastern portion of Alabama. No other MTFs are located in the catchment area.

The overwhelming majority, almost 80 percent, of MACH's customers live within 20 miles of the hospital. Most of the remainder are located in the Auburn and Eufaula, Alabama areas along the northwestern and southwestern periphery of the catchment area. For a variety of reasons, MACH also draws some patients from outside the assigned catchment area. First, the hospital is located on Fort Benning, Georgia which is a major attraction to the retired population. Fort Benning is located in Columbus, Georgia, which is the one of the largest cities in the area where military benefits are available. Most of the southern region is rural and medical resources are generally limited to only a few of the larger towns. Atlanta, Montgomery, and other major cities are a two to three hour drive for most residents. Finally, closure of Fort McClellan in Alabama will result in a shift of some 1,500 customers to MACH as well.

A large segment of the active duty beneficiary population and their dependents live in military housing. There are 4,270 base housing units; a private management company owns 200. Occupancy is not a problem, as there is usually a waiting list for housing (James Hankins, personal communication, January 28, 1999). Units

are typically full; normally, vacancies only occur when transitioning between tenants.

There are also 14,728 single-occupancy spaces on Fort Benning designated for unmarried active duty members. Additionally, there are 2,884 spaces for students attending various training courses. Although many of these single-occupancy spaces are being renovated, there is no plan to increase the overall number of spaces (James Hankins, personal communication, January 28, 1999).

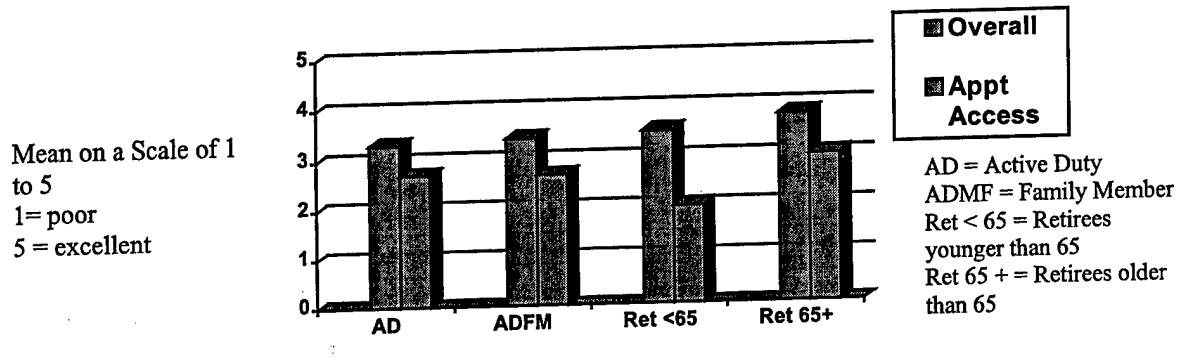
Needs/Wants/Surveys/Assessments:

A critical component of marketing is an understanding of customers' needs. The following addresses customers' needs from a macro, MHS, level all the way to a more micro, MACH catchment area, level. Military provider perceptions are also included.

At the MHS level, lack of access to the DOD's MTFs is the number one beneficiary concern according to Dr. Joseph, the recently retired Assistant Secretary of Defense for Health Affairs (Chapman, 1996). Health Affairs conducted a beneficiary survey in 1997 which concluded satisfaction varies by beneficiary category, type of facility, and the dimension of care. The sample consisted of 170,000 adults and 30,000 children. Satisfaction differences by beneficiary type are portrayed in Figure 5.

Figure 5.

Overall Satisfaction and Appointment Access Satisfaction Ratings by Beneficiary Type

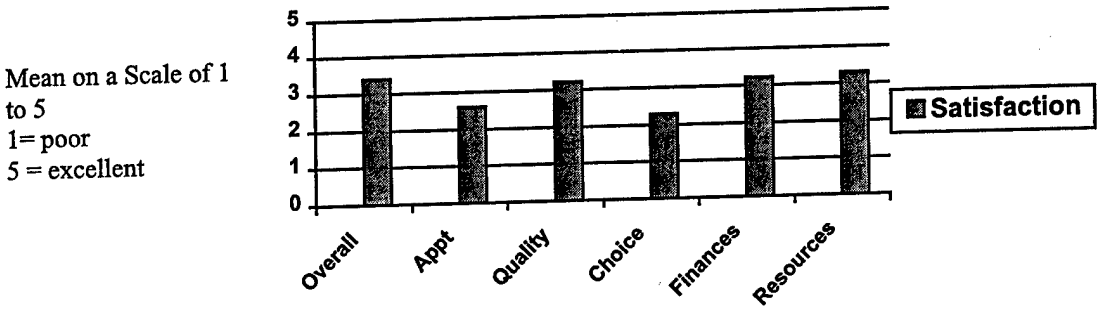


(Source: HA Beneficiary Survey, 1997)

Beneficiaries also consistently rated civilian facilities one-half to one point higher than military facilities on the same one to five scale, satisfaction also varies at the MTF depending upon the dimension of care, as detailed in Figure 6. The survey also evaluated knowledge of TRICARE throughout the DOD. Figure 7 shows the level of knowledge about TRICARE among those surveyed.

Figure 6.

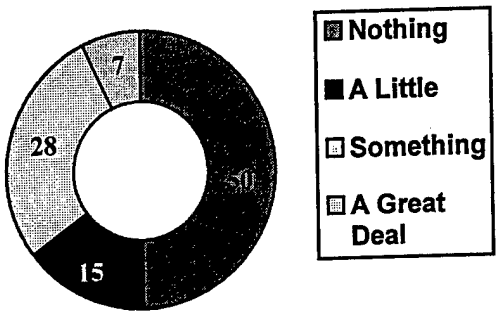
Satisfaction by Dimension of Care (Mean on a 1 to 5 Scale)



(Source: HA Beneficiary Survey, 1997)

Figure 7.

Knowledge of TRICARE
(as of Spring/Summer 1997)



Percentage

(Source: HA Beneficiary Survey, 1997)

Patient wants and needs from other regions are also valuable to understand. The results of a survey conducted in Region 11, the region where TRICARE has been operational the longest and is in the Northwestern part of the country, follow. Almost a year after implementation, one-third of Prime enrollees reported access vastly improved; while 15 percent said access declined.

> Respondents also reported improved access to primary and specialty care, and a significant minority report shorter office waiting times and better continuity of care. Those assigned to civilian primary care managers or referred to a civilian specialist were more likely to note improved access. Quality of care is as good or better under TRICARE, according to the survey. The biggest improvements are associated with specialty care. 45% of those contacted who saw a civilian specialist and 35% who visited a military specialist reported quality improvements. Only 1 in 4 enrollees contacted used TRICARE contractor-provided nurse adviser telephone lines. Those who did, however, rated the service highly, and more than half said the call saved a trip to an emergency room or physician. Respondents said TRICAREs toll-free information

lines are slow, but they gave operators and TRICARE representatives at military medical facilities high marks for courtesy and explaining how the program works. On the other hand, they rated the helpfulness and courtesy of reception staffs at military facilities much lower than those at civilian primary care facilities. 4 out of 5 said they plan to re-enroll in TRICARE Prime, and only 5 percent said they'd switch options. 72% of active duty dependents who made a co-payment to a civilian physician think Prime's co-payments are reasonable; 46% of those who haven't made a copayment agree. More than 1/3 of retirees and their dependents polled don't like paying annual enrollment fees. However, those retirees who paid for civilian care before TRICARE Prime was available were happiest with the annual fee. Less than a third said the annual fee caused them serious financial hardship (Survey Gauges TRICAREs Impact on Health Care, 1997).

The following information pertains to MACH customers specifically. MACH enjoys huge market share and customer loyalty. Unfortunately a significant portion of those customers would be tempted to go outside the MHS if costs were less of a factor. Chief complaints among MACH's patients are limited access, reassurance and support offered by health care provider, amount of time spent with health care providers during a visit, and the health care providers' personal interest in the patient's outcome. Other patient concerns include thoroughness of examination, ability to diagnose a health care problem, and thoroughness of treatment (HA Beneficiary Survey, 1997).

Providers' perceptions, wants, and needs are also important. OASD-HA conducted TRICARE Focus Groups in Regions Five, Nine, and

Two in May of 1995 and Regions Six and Two in December of 1995. Common themes expressed by the providers include:

- Access has improved for those in TRICARE Prime, but the improvement has come at the expense of those who have not enrolled, particularly retirees.
- They are frustrated with their patients' lack of understanding of the program.
- Provider briefings did not adequately address military physician concerns and lacked credibility.
- They do not want to be sold on the program; but would rather see data of the claims that TRICARE will have a positive impact on the lives of physicians and the MHS.
- Providers want assurance that TRICARE will not negatively impact their daily work, their long-term careers in the military medical corps, and graduate medical education.
- They are being asked to explain TRICARE to patients, but do not fully understand it themselves.
- They fear being compared to civilian doctors and because of their military obligations, these comparisons may be used to further drawdown military medicine.
- Some expressed fears that managed care increases their workload. They think military providers are not equipped to see more patients because of the lack of support, resources

and technology in MTFs, as well as their non-clinical military duties (TRICARE Focus Group Reports May 1995 and December 1995).

Some of these provider concerns are legitimate, while others are not. Regardless, providers will dramatically impact the success or failure of TRICARE. Provider concerns must be addressed and providers should be involved throughout the TRICARE process.

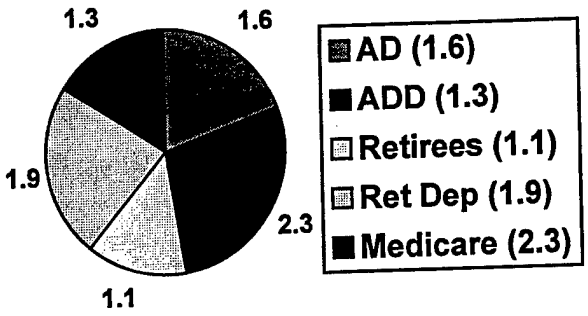
The Market - Quantitative

It is also important to understand who the customers are and where they live. The following, again looks at the customers from a macro, MHS, view down to a micro, Fort Benning, view.

The Defense Department estimates that roughly 6.4 million of 8.2 million eligible beneficiaries currently use MTF's. Almost all active duty members and their families, totaling 4.2 million, use military medical facilities. Only about two-thirds of the three million military retirees and their dependents under age sixty-five use MTFs regularly (Chapman, 1996a) Figure 8 provides a breakout of the 8.2 million eligible beneficiaries by category.

Figure 8.

MHS Beneficiaries by Category
1997 (millions)



(Source: Chapman, 1996a)

Some 380,000 military retirees and dependents aged 65 and older used MTFs exclusively during 1997. Another 600,000 used MTFs occasionally. It cost the DOD about $1.4 billion to treat them (Chapman, 1997). There are currently 148,297 retirees 65 years of age or older.

Region Three includes roughly 13.1% percent of the entire MHS eligible population, which makes it responsible for more beneficiaries than any other region. Health Services Region (HSR) Three or Region Three includes 393,474 eligible who reside in Georgia and Alabama beneficiaries (Managed Care Forecasting and Analysis System MCFAS, 1999). Roughly 49% percent of the total eligible population live in non-catchment areas (i.e., further than 40 miles from a MTF (MCFAS, 1999). Additionally, 20 percent of

Region Threes eligible beneficiaries are Medicare eligible (MCFAS, 1999).

Approximately 67% percent of Region Three beneficiaries are CHAMPUS eligible (MCFAS, 1999). More than $383,279,816 million in 1998 CHAMPUS expenditures in HSR Three provide 30,697 annual hospital admissions and 2,236,534 outpatient visits (CHAMPUS Medical Information System, 1999).

Just less than three percent of the approximate 1 million MHS eligible beneficiaries within HSR Three live in Georgia. Nearly 49% percent of the Georgia population live in non-catchment areas. Approximately 13.7% percent of Georgia and Alabama's MHS population is Medicare eligible (MCFAS, 1999).

Table 5 reports the specific MACH Catchment Area population and projected population by beneficiary category (active duty, active duty dependents, guard/reserves and their dependents, as well as retirees and their dependents, and survivors).

Table 5. MACH Catchment Area Projected Population by Beneficiary Category

	1995	1996	1997	1998	1999	2000	2001
Active Duty	18905	18251	20584	20346	15281	15275	15280
Dep	25417	23572	23883	23286	20717	20712	20680
Guard/Res	180	458	430	2294	345	346	342
Dep	334	399	281	301	289	284	280
Ret	11021	11350	11424	11415	12095	12312	12545
Dep	15725	16382	16481	16136	17165	17434	17706
Survivor	3399	3479	3535	3529	3865	4013	4139
Other	167	268	167	185	186	184	186
Total	**75148**	**74159**	**76785**	**77492**	**69943**	**70560**	**71158**

(Source: Naval Medical Logistics Command, 1999)

Table 6 further describes the MACH catchment area population by gender and age.

Table 6. MACH Catchment Area Projected Population by Gender and Age

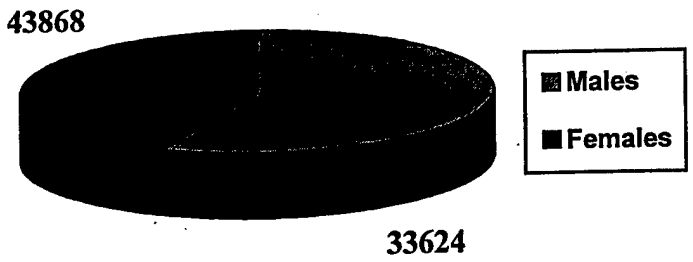
Gender	Age	1995	1996	1997	1998	1999	2000	2001
Male	**0-4**	2829	2828	2820	2735	2600	2631	2598
Male	**5-14**	5495	5567	5582	5442	4914	4922	4951
Male	**15-17**	1563	1684	1724	2556	1556	1540	1554
Male	**18-24**	10635	10938	12606	12959	9455	9500	9513
Male	**25-34**	6154	5727	6214	6407	4883	4896	4853
Male	**35-44**	3959	3853	3912	3924	3332	3300	3289
Male	**45-64**	6002	5820	5731	5684	5849	5965	6089
Male	**65 +**	3628	3750	4006	4161	4619	4740	4882
Female	**0-4**	2657	2720	2750	2678	2476	2480	2517
Female	**5-14**	5578	5477	5381	5331	4748	4792	4710
Female	**15-17**	1409	1473	1495	1460	1434	1403	1437
Female	**18-24**	4427	3861	3974	3800	3941	3984	3973
Female	**25-34**	5676	5305	5293	5012	4482	4447	4501
Female	**35-44**	4199	4089	4184	4175	3822	3771	3846
Female	**45-64**	6692	6613	6429	6364	6539	6680	6712
Female	**65 +**	4245	4454	4684	4804	5293	5509	5733
	Total	**75148**	**74159**	**76785**	**77492**	**69943**	**70560**	**71158**

(Source: Navel Medical Logistics Command, 1999)

Figure 9 graphically depicts the current MACH catchment area gender distribution.

Figure 9.

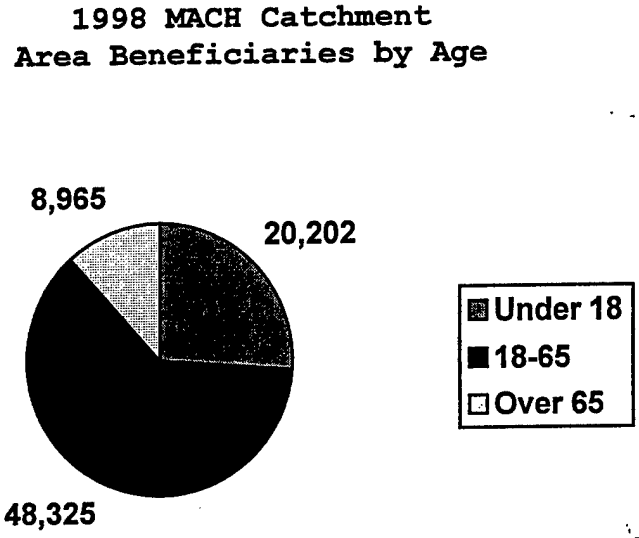
1998 MACH Catchment Area Beneficiaries by Gender



(Source: Navel Medical Logistics Command, 1999)

Figure 10 graphically depicts the current MACH catchment area by age.

Figure 10.



(Source: Navel Medical Logistics Command, 1999)

Trend Analysis

Trends are addressed in the following categories: downsizing, manpower reductions, costs, demographics, marketing, enrollment/re-enrollment, enrollment-based capitation and other trends.

Downsizing

We talk about downsizing and rightsizing, but the fact is the United States has been in the process of demobilizing. Our nation demobilizes after every war because we are fundamentally a militia nation (Blanck, 1998). Understandably, Americans grew accustomed

to having a large military; during the Cold War, the nation for the first time maintained a large standing military force (Chapman, 1996). The reality is that as the military moves forward into the future, they will have fewer people, fewer medical facilities, but the goal will be to have the right resources and technology to provide top quality care for all our people (Blanck, 1998). Since 1989 the Army has been reduced by 38 percent, but the pace of operations has gone up significantly (HQDA, 1998). Defense Secretary William Cohen also revealed military troop strength is down 33 percent in recent years, while infrastructure has been cut only 18 percent. According to Cohen, that leaves significant excess capacity (USA Today, 1997).

The MHS has also shrunk. In 1997, the MHS had closed 58 hospitals - 35% of the entire system that existed in Fiscal 1988 (Chapman, 1996a). Since 1989, the number of operating beds has been reduced by 21 percent, military hospitals by 30 percent, and military and civilian medical staffs by 13 percent. During the same period, the DOD beneficiary population decreased by only about 8.5% (Chapman, 1996). Interestingly the military medical force has shrunk faster than the total number of beneficiaries (Chapman, 1996). This can be attributed primarily to the growth in the number of retirees and their dependents.

Manpower

A component of the downsizing that has began and continues is the reduction of personnel. Between fiscal years 1989 and 1999, the Army will cut its active military personnel from more than 295,741 to 474,000 - a 38 percent reduction (HQDA, 1998). Mission forces were reduced at a much greater rate than infrastructure forces (i.e., support personnel including medical etc.), about two-thirds of present active duty forces are allocated to these support functions. The GAO contends it is possible to further reduce the active Army well below the 474,000 threshold without affecting war-fighting capability. These numbers are close to those of the Army Air Corps just after the dramatic demobilization after World War II (Boyne, 1997).

General Blanck, the Army Surgeon General, stated medical manpower would be reduced by 17.9 percent between FY89 and 2008. (Blanck, 1998). This all comes on the tail of the 733 Study, which was mandated by the National Defense Authorization Act for FY92 and FY93 that questioned the size of the military health care system. It suggested the DOD had as many as twice the number of physicians it needed to meet wartime requirements (U.S. GAO, 1995). General Blanck has indicated the Army Medical Service will only get as small as the readiness mission dictates. In other words, readiness

will be the floor and anything done over and above that must be justified with business case analysis.

Costs

In the 1980s, MHS costs rose more than the nation's, 225 percent to 166 percent, respectively. The greatest portion of growth occurred in the CHAMPUS program that grew by about 350 percent during this period. The medical portion of the Defense budget doubled, from three to six percent of the total in the same period (U.S. GAO, 1995). The chief drivers of the cost growth were a growing military beneficiary population that made greater use of health care services than its civilian counterparts and a system of resource allocation that encouraged managers to increase hospital workload (U.S. GAO, 1995). Those cost issues coupled with the so-called peace dividend, the closure of military bases and military drawdown, drove the military to look for new ways to provide the health care benefit. TRICARE is the DOD's response to these challenges (Gillert, 1996).

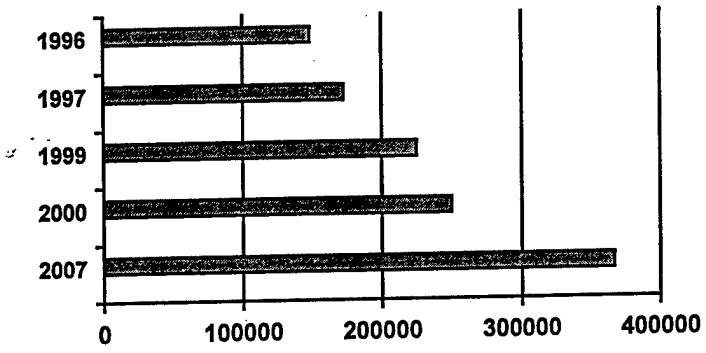
More recently however, even before establishment of TRICARE, the MHS has been driving down its cost. Between 1994 and 1996 CHAMPUS cost rose 3.8 % and the cost of the overall defense health program increased by only 1.2%. The national average for health care cost inflation was over 7% during that period (Chapman, 1996).

Demographics

In 1996 there were 148,297 retirees 65 years of age or older eligible for care in the MHS. Between 1997 and 2007 that figure is projected to grow to approximately 366,885, as illustrated in Figure 11.

Figure 11.

Medicare Eligible Military Retirees



(Source: Chapman, 1997)

The trend is consistent with the graying of America.

Another major projected demographic change is the continued increase in the number of Hispanics. By the year 2050, one in every five people living in the United States will be Hispanic (Profiles, 1996b). These demographic trends need to be kept in mind. Even though the aggregate number of Columbus beneficiaries is expected to remain fairly constant in the near future, the number of TRICARE eligible beneficiaries will shrink slightly as the number of Medicare eligibles increases.

Marketing

The driving force behind the growing health care marketing industry is the price compression that began to occur in hospitals in the last decade; as revenues dropped, the lunge for market share began (Roman, 1996). Marketing is definitely a corporate practice and now it is evident the "...M-word" (marketing) has arrived (Nursing Times, 1993). With that in mind, it is important to understand health care marketing trends. Physician's Marketing and Management claims clinical outcome studies will become critical in health care marketing as managed care customers demand documentation to prove quality. This proof may allow health service organizations to command a premium in contract negotiations (Physician's Marketing and Management, 1996a). Hull validates this by stating although outcomes are not important yet, they will be soon (Hull, 1996). Jaklevic reported a similar trend; as prices stabilize, purchasers will pay closer attention to quality. Report cards are one way to convey the quality message and hospitals are now publishing their own report cards. These report cards vary widely in presentation style, types of data offered, and target readership, but they are all meant to feed increasing consumer demands for accountability (Jaklevic, 1995). Hospitals are also using patient satisfaction information for marketing purposes (Health Care Advisory Board, 1994b). While outcomes, quality, and

patient satisfaction impact health care marketing efforts, other trends also abound.

The Health Care Advisory Board believes marketing should be treated as an investment, which should be tracked, measured, and evaluated for reasonable returns (Health Care Advisory Board, 1995a). Another notable trend is the decline in marketing budgets. Between 1993 and 1994 the average hospital marketing expenditure fell 3.3 percent (Health Care Advisory Board, 1995a). However, national spending on health care marketing has increased by about $6 billion since 1990 (Roman, 1996). The personal selling of health care services will grow in importance in the future ((Koehler and Van Marter, 1995). Prevention and wellness will become a very popular marketing scheme for general physicians and internists, as it has been for managed care organizations and giant hospitals (Profiles, 1996c). Consumer-oriented marketing is sparking debate.

Surprisingly, the Health Care Advisory Board believes consumer-oriented health care marketing will disappear as overall managed care penetration increases. Hospitals' and health systems' marketing departments will be forced to apply their expertise to attracting physicians and managed care contracts, rather than marketing directly to consumers (Health Care Advisory Board, 1994c). In support of this, they also believe traditional

marketing media such as radio, television, and newspaper will be replaced by forums such as direct mailing and billboards targeted to specific markets (Health Care Advisory Board, 1995a). This statement is somewhat contradicted in a later report that claimed... brand awareness is an invaluable asset (Health Care Advisory Board, 1995a). They cover their tracks by stating, although current marketing trends indicate hospitals are spending less time on consumer-directed programs and more time marketing to payers and employers. All of the sources contacted for this report noted that underestimating the importance of the consumer is a fatal flaw (Health Care Advisory Board, 1994c). Upton agreed when he stated consumer voice is an emerging power particularly in the managed care context (Upton, 1995). The mechanisms used for health care marketing are also changing.

There are tools which will become even more important in the successful marketing of health care. Medicine on the Net claims the World Wide Web is an ideal outlet to market health care services (Medicine on the Net, 1996). Health care marketers are now also using information systems for planning prevention campaigns and new health services, analyzing health factors and disease incidence, determining where to target market, or even for setting up a physician network (Capitation Management Report, 1995).

Enrollment/Re-enrollment

Enrollment and re-enrollment are constant concerns in the civilian sector. The impact of those concerns are captured in Table 7.

Table 7. Civilian Sector Enrollment Concerns

18 % of HMO enrollees have been in current plan for less than one year
39% fo consumers report swithching physicians due to dissatisfaction
One-third of senior HKO defections occur within the first three months of enrollment
53 % of commercial enrollees switched plans in the last 3 years

(Source: Health Care Advisory Board, 1996)

Table 8 depicts TRICARE Prime enrollment with a MTF PCM in regions located in the continental United States.

Table 8. Percentage of TRICARE Prime Beneficiaries Enrolled with a MTF PCM by Operational Region

Region	Enrolled Beneficiaries with MTF PCM	Total Enrolled Beneficiaries	Percent of Enrollees with a MTF PCM
1	172585	218426	79%
2	229158	245883	93%
3	237554	29224	81%
4	111565	165331	67%
5	114522	135089	85%
6	241406	325683	74%
7	54081	55506	97%
8	288508	333733	86%
9	129510	187674	69%
10	40898	79217	52%
11	103601	138515	75%

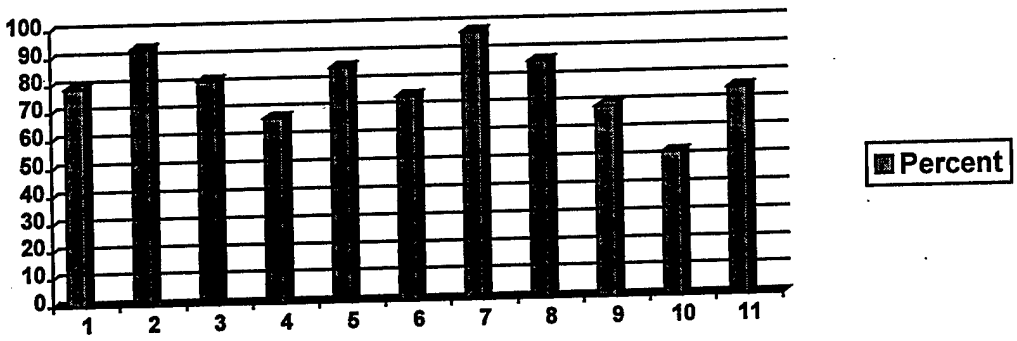
(Source: Adapted from the Health Affairs TRICARE Enrollment Report, 1998)

This percentage was calculated by taking the total number of beneficiaries enrolled in TRICARE PRIME divided by the number of beneficiaries enrolled with a MTF PCM. Of all the regions

depicted, Region Three ranked 5th in beneficiaries enrolled with a MTF PCM. Figure 12 graphically illustrates these enrollment percentages.

Figure 12.

Percentage of TRICARE Prime Beneficiaries Enrolled With a MTF PCM by Operational Region



(Source: Adapted from the Health Affairs TRICARE Enrollment Report, 1998)

It is important not to include active duty personnel when measuring enrollment; granted they are enrolled at the MTF, but they are actually not in TRICARE, since TRICARE is only for CHAMPUS eligible beneficiaries. Therefore by including active duty in the enrollment computation, the percentages are improperly skewed higher. However, whenever comparisons are made to other regions, care should be taken to ensure all comparisons are measuring the populations in the same fashion.

Enrollment-Based Capitation

Dr. Joseph directed the MHS move to enrollment-based capitation resource allocation beginning in October of 1997. The details are still being developed - however, according to a draft policy letter, enrollment-based capitation will have the guiding principles listed in Table 9.

Table 9. Projected Enrollment-Based Capitation Principles

MTF commanders should be fully accountable for all resources needed to support their enrolled population
Decisions to provide high-quality, cost-effective, and clinically appropriate health care services should be incentivized and supported at every organizational level throughout the MHS.
Initial financing of MTF budgets by the three Military Departments will be based only on enrolled beneficiaries.

(Source: Joseph, 1997)

Potential exceptions to enrollment-based capitation are shown in Table 10.

Table 10. PROJECTED EXCEPTIONS TO ENROLLMENT-BASED CAPITATION

Financing of space-available care for dual eligible Medicare beneficiaries will be based on the historic level of effort appropriately adjusted until enrollment of dual eligible Medicare beneficiaries can be achieved.
Tertiary care teaching MTFs will require some quantifiable adjustment factor for graduate medical education.
Current capitation expenses (medical readiness and training requirements) attributable to the MTF, but are not included in the enrollment based capitation allocation.

(Source: Joseph, 1997)

This policy is also expected to authorize transfer payments between facilities. That simply means an organization will have to pay other MTFs or the MCSC for care rendered to that organization's enrolled patients. Similarly, if that organization treats other MTFs' enrollees, TRICARE Standard, or TRICARE Extra beneficiaries, the organization will be entitled to collect for rendering that care. Members of MACH should pay close attention to the details of the policy as it evolves since it will have such a dramatic impact on the budget.

Other Trends

Other trends impacting the MHS include: fewer medical centers, community health prevention, PCM teams, wellness, and prevention. These trends can quickly change depending upon the policies enacted by military leaders and elected officials.

Competition

MTFs face potential competition from local health maintenance organizations (HMOs, other managed care entities, and other health care organizations) that might seek to enroll non-active duty beneficiaries into their health plans. To combat this threat, MTFs are positioning themselves today to become their customers' healthcare provider of choice.

Specifically in Columbus, Georgia, MACH and much of the local health care community are undergoing increased competition in health care, making it more of a buyers' market. It is safe to say that

surrounding hospitals are aggressively marketing new services and programs; building bigger, more and more attractive facilities; and expanding their networks and affiliations. More private centers are providing high-tech services in direct competition with these hospitals as well.

MACH should remain aware of health plan activities in the metropolitan areas near Columbus (i.e., Atlanta, Montgomery, Birmingham) as it would be quite easy for a plan to expand into the Columbus marketplace. Close proximity is not the only concern, in a highly competitive managed care market, health plans and other health care organizations are continually looking for opportunities and could quickly enter the Columbus market. Therefore, it is vital for the organization to continually monitor the pulse of the managed care environment across the country.

Hospitals

The following information regarding competitive hospitals was extracted from the Georgia State Health Planning Agency:

The Medical Center (TMC) is a 413 bed facility located 13 miles northwest of MACH in Columbus. They provide inpatient, outpatient, emergency and health education services for more than 124,000 people annually. In FY 97, TMC had 47,912 emergency room visits, 12,640 admissions, and over 64,000 outpatient visits. TMC offers an array of

tertiary level services, many of which are available nowhere else in the region. These include the region's only dedicated trauma center; Level-III (or advanced) obstetric services and a neonatal intensive care unit, or high-risk nursery; and pediatric intensive care services. TMC also is home to the region's only civilian training program for family practice physicians.

TMC has extensive marketing and community outreach programs which include: the CommunityCare Mobile Health Unit which provides health and educational services throughout the region, the TRUST Program which addresses the needs of abused children, and the Adolescent Pregnancy Prevention Program which provides teen family planning services. In addition, it sponsors a rural Perinatal Transportation Project which address transportation barriers to the rural communities, the Regional Education Program which focuses of prevention and wellness education, and the District Dental Service which provides pediatric dental services and educational services to children.

Renovation projects planned and begun during the year will result in enhanced services for patients at TMC. These include a $350,000 project in the Emergency department to improve areas for registration, reception, triage and express care. A phased renovation of patient floors includes approximately $400,000 in enhancements to 7 Main nursing and patient care areas and $100,000 has been dedicated to

renovate the Rehabilitation department. A $2.2 million nursery renovation project is underway which will be completed in late 1999.

TMC and MACH enjoy an excellent working relationship. TMC serves as the network provider the majority of the inpatient services. TMC is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and is a member of the American Hospital Association (AHA).

Doctors Hospital (DH) is a 219 bed hospital also located 13 miles northwest of MACH. They provide education services as well as inpatient, outpatient, emergency services for more than 51,000 beneficiaries annually. In FY 97, DH had 21,412 emergency room visits, 5,705 admissions, and over 24,000 outpatient visits. DH has more than 250 physicians, a medical support staff of 420 and offers a variety of impatient and outpatient programs.

In addition to full medical and surgical services, DH facilities include the following centers: emergency, behavioral medicine, birthing, business health, cancer, metabolic disorders, outpatient surgery, senior health, women's imaging and sleep disorders.

DHs community evolvement and marketing efforts include various community education programs such as PRIMETIME which is a geriatric program focusing of the special needs the older adults, CPR classes, smoking cessation classes as well as others. DH is also accredited by the JCAHO and is a member of the AHA.

Hughston Sports Medicine Hospital (HSMH) is a 100 bed facility located 15 miles north of MACH. Founded by Dr. Jack Hughston, known internationally as the "father of sports medicine," HSMH is among the country's top sports medicine facilities. HSMH is among the nation's first hospital designed specifically to treat patients suffering from sports or activity-related injuries and disorders. Fully equipped and supported by a medical staff known for their expertise in musculoskeletal disorders, their major services include: sports medicine, joint replacement, a back program, short-term rehabilitation, and general orthopedics. Fully accredited by JCAHO, the hospital is supported by orthopedic physicians of the HSMH. HSMH also has a medical support staff of 370 employees and offers a variety of inpatient and outpatient programs.

Saint Francis Hospital (SF) is a 292 bed facility located 17 miles north of MACH. SF is noted throughout the state of Georgia for it's cardiac care. Additionally, they provide mental health, wound care, home health, home medical equipment and rehabilitation services for more than 67,000 beneficiaries annually. In FY 97, SF had 21,811 emergency room visits, 6,985 admissions, and 31,067 outpatient visits.

Though the focus of SF is cardiac care, their commitment to the community extends beyond diagnosis and treatment. Their primary outreach programs include a 24 hour a day, 7 day a week free Ask-A-Nurse phone service which processes more than 6,000 callers each month and an

education and screening service called Health Matters located in the local mall. Health Matters provides blood pressure checks and heart-risk appraisals as well as a classroom facility hosting physicians and health specialists who present educational classes on topics of interest for the community.

Problems and Opportunities

Problems and opportunities are presented in Strength, Weaknesses, Opportunities, and Threats (SWOT) Analysis format as presented below. Many fall into more than one category. For example, threats may also offer opportunities. Threats appear to outweigh opportunities in the sheer number. This can be attributed to the fact that TRICARE is still relatively new and there are still may questions which have yet to be answered. With that in mind, all threats should be viewed as opportunities. Also, many of the strengths, weaknesses, opportunities, and threats are global in nature and do not apply to MACH only, but can be generalized across the entire MHS. More details on each follow.

STRENGTH (SWOT)

- **Lowest cost option for most beneficiaries** All MTFs are competitive in terms of cost to the patient and quality of care. MTFs have a tremendous least cost advantage over their competitors. They can also differentiate themselves on the high quality of care that exists. Russel Coile Jr. informed the Missouri Hospital Association

in November of 1996 that 80 percent of consumers select the cheapest product (Coile, 1996).

- MTF Commanders will designate whether enrollees in the catchment area have MTF or network PCMs (MCSC, 1996). The contractor will assign enrollees to PCMs in accordance with the Lead Agent and MTF Commanders' determinations. The contractor shall assign enrollees to PCMs at the MTF until the maximum capacity is reached in accordance with the **MTF commander's determination**, and assign all other enrollees PCMs in the contractor's network (MCSC, 1996). This provides an exceptional competitive advantage. It is important to note the commander can not require beneficiaries to select Prime, but if they do select Prime the commander may assign the MTF as their gatekeeper.
- **Competitive in terms of cost to the government.** A 1990 General Accounting Office study concluded the military could save money by treating patients in MTFs rather than with CHAMPUS providers (Chapman, 1996a). The 733 Study, also concluded that MTFs could provide health care less expensively on a case-by-case basis than can CHAMPUS. In fact, the study found a price advantage of ten to twenty-four percent for a given work load through a MTF as opposed to CHAMPUS (Chapman, 1995). This advantage can be attributed to five factors, which are portrayed in Table 11.

Table 11. Factors Which Enable MTFS to Achieve a Price Advantage Over CHAMPUS

1) MTFs provide care in more austere settings than civilian facilities do.
2) The military system, with some exceptions, is under less pressure to adopt unproven technologies, thereby slowing the pace of technology driven cost growth.
3) DOD has no financial responsibility when malpractice claims are upheld in court.
4) DOD is responsible for almost no indigent care.
5) Because military physicians are salaried employees, they have less incentive to prescribe greater amounts of testing and treatment that may be of marginal benefit.

(Chapman, 1995)

However, increased MTF usage would actually raise costs. According to a RAND Corporation study, for every ten patients pulled into MTFs from CHAMPUS, the MTFs would also see about six patients who would have sought care through third-party insurance or would have deferred care entirely - creating a total new workload of sixteen while saving only the cost of ten from CHAMPUS. The RAND analysts also found a secondary effect: with expanded opportunity for free MTF care those who had been using the system would do so more frequently. That would add yet another three cases for every ten pulled from CHAMPUS. Thus, the total increase would actually be nineteen, not ten - generating what DOD terms 'the demand effect' - nearly doubling the original CHAMPUS workload potentially transferred to the MTF. The demand effect would wipe out any cost advantage (Chapman 1995).

- MACH **staff is a portion of the target audience.** They live next door to a large segment of their target population and have a similar frame of reference and past experiences. The staff interacts with

this segment of the target audience daily and has ample opportunity to continually sell TRICARE - to their friends and neighbors.

- The **point of service (POS)** option gives MACH the ability to combat beneficiary concerns regarding lack of provider choice. This option allows TRICARE Prime enrollees the ability to see a provider without a referral from their PCM.
- **Nationally guaranteed benefits** include outpatient care, inpatient care, prescription drugs, radiology, laboratory, mental health, drug counseling, and preventive care. TRICARE benefits are defined and consistent. While the benefits are the same, not all TRICARE options will be available in every location. It may not be economically feasible for the MCSC to establish Prime and Extra networks in every location.
- TRICARE **compares favorably to civilian health plan experiences** for beneficiaries. Employers typically offer only one or a few health plans, the task of identifying and comparing products is greatly simplified or eliminated (U.S. GAO, 1996). While it does compare favorably, many of the target beneficiaries have not had to make many choices regarding their healthcare in the past.
- **Right of First Refusal.** Nonavailability of MTF specialty services will be established prior to referring enrollees to network providers (MCSC, 1996). This allows the MTF to shop between network providers and services offered in the area.

- MACH is **JCAHO accredited.** They meet the same requirements as civilian institutions they do business with.

WEAKNESSES (SWOT)

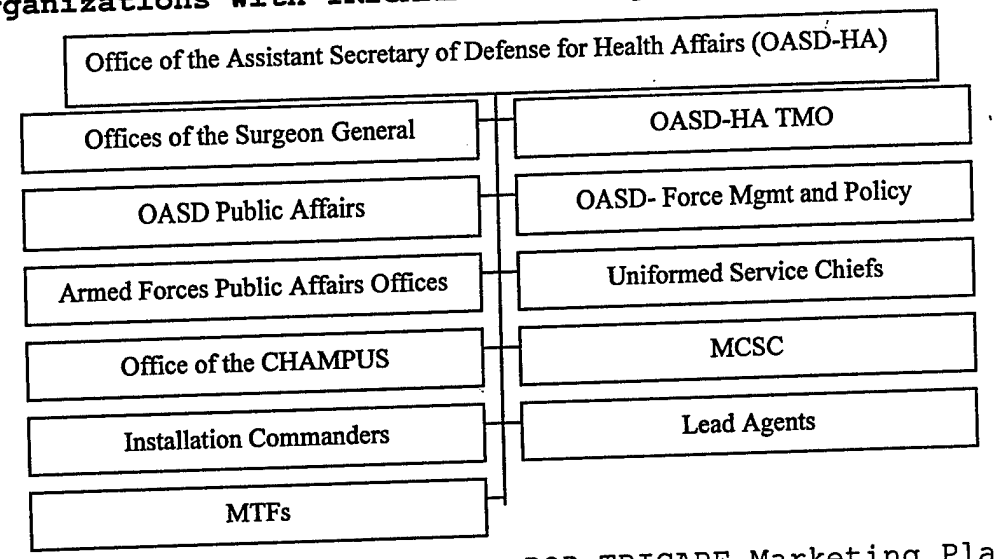
There is a **poor understanding of TRICARE among beneficiaries.** At first glance, TRICARE appears confusing and there is misinformation spreading among the beneficiary population (U.S. GAO, 1998). Beneficiary confusion caused by education and marketing problems exists (U.S. GAO, 1996). Dr. Joseph, the former Assistant Secretary of Defense for Health Affairs, contends education is the Achilles' heel and everyone involved must do a better job of educating beneficiaries on the benefits of TRICARE (Joseph, 1996).

- **Open enrollment is a major weakness of TRICARE.** The plan will provide for continuous open enrollment with a 12-month enrollment period. Beneficiaries may choose to disenroll after each of their annual enrollment periods has expired. Beneficiaries who select disenrollment during their annual re-enrollment period may choose to reenroll at any time (MCSC, 1996). Beneficiaries who request early disenrollment or are disenrolled by the contractor for non-payment of their quarterly enrollment fees (retirees only) are not entitled to re-enroll for a period of 12 months (MCSC, 1996). It may prove difficult to manage the health of a population that can disenroll and re-enroll basically at any time.

Marketing roles and responsibilities are spread over a broad spectrum of organizations and levels. The TRICARE Marketing Office (TMO) Marketing Plan statement, that the successful marketing of TRICARE requires the coordination and support of many DOD organizational elements (DOD, 1998) is an understatement. Typically, when it is everyone's responsibility to do something, it does not get done because everyone thinks someone else is doing it. This could also create a situation where duplication of effort and lack of coordination flourish, resulting in inconsistent messages and disjointed presentation. Figure 13 displays organizations which all have TRICARE marketing roles and responsibilities.

Figure 13.

Organizations with TRICARE Marketing Responsibilities



(Source: DOD TRICARE Marketing Plan, 1998)

- The **TRICARE brand does not create a clear or simple positioning theme** for the MTF. Civilian TRICARE PCMs and MTF TRICARE PCMs are lumped

all together. To further complicate matters, TRICARE Extra, TRICARE Standard, and the POS option cloud the issue. It is unclear if the names articulate the desired positioning of the product. The name TRICARE Prime does not uniquely identify a particular organization.

- **Continuity of Care** may be a major weakness if providers are deployed from the MTF. If civilian PCM providers are not in the Reserves or Guard they will enjoy a distinct competitive advantage, being better able to provide continuity of care. MTFs face potential major disruptions of service generated by deployments. Granted, beneficiaries' health care needs will be met through resource sharing, resource support, backfill by other military personnel, or use of network providers but continuity of care will be greatly reduced.
- The **regional structure** of TRICARE does not provide sufficient authority and control over resources. The Lead Agent is responsible for regional health care delivery but the major commands still retain primary fiscal responsibility for MTFs and their operations. Of major concern is the lack of control by Lead Agents (Chapman 1995). Lead Agents have little real authority over hospital commanders, who are still being controlled by their own service. This regional structure appears to still be evolving. The Lead Agent at regions seven and eight have consolidated and others may soon follow. While economies of scale may be realized, support to the MTFs could suffer.

- **Service** is our Achilles' heel. **Ease-of-use** (including access) and exhibiting a caring attitude are our biggest weaknesses; they are also many of our competitors' greatest strengths. While patient surveys throughout the MHS indicate a high degree of satisfaction, our customers consistently score civilian competitors higher. Service remains our weakest differentiating factor. MTFs must improve their service so they are the easiest healthcare system to use in their local market. While TRICARE holds the MHS to the same access standards as civilian counterparts; the use of such things as preauthorization may not necessarily enhance ease-of-use. Many civilian health care organizations have recognized the pendulum is swinging and are relaxing these types of procedures just as the MHS is implementing them.
- The **partnership with a health plan** makes for a strange bed fellow. While a health plan can be an asset to a health system, these two entities sometimes have conflicting interests (Health Care Advisory Board, 1995b).
- The **procurement process** is cumbersome and contentious. DOD's experience with contracting for private-sector health care services is proving to be cumbersome, complex, and costly, resulting in contracting protests, schedule delays, and an overall lengthy procurement process (Chapman, 1995). It will be difficult to compete

with civilian entities that are not tied to this type of bureaucratic process.

- True **uniformity in benefits and cost sharing has yet to be achieved.** Inequities still remain because not all beneficiaries will have access to all three options (TRICARE Prime, Extra, and Standard), since medical resources vary by location. Beneficiaries in the MACH Catchment Area will have access to all three options; however, the extent may vary because of the various specialty shortages, number of hospitals etc.
- **Our ability to manage risk is unproven.** Even though MTFs have operated on a fixed budget in the past, money was routinely diverted to poor performing facilities or organizations that experienced unexpected expenses. There is also no real incentive for providers to manage risk, primarily because they are employed physicians and their salary cannot be affected in the short run. Enrollment-based capitation does not even affect them financially. While the threat of the stick always exists, few Deputy Commanders of Clinical Services exercise that type of power. Hopefully, by showing them how their efforts compare to other providers they will embrace this change.
- TRICARE Prime is the **option of least** choice for the beneficiary.

- There is a **lack of marketing expertise** in the service. In the past, military health care professionals have not had much need or opportunity to develop marketing skills.
- **Marketing materials will be designed to attract beneficiaries who are high-cost users of CHAMPUS.** The contractor will identify specific steps to induce those beneficiaries, when appropriate, to enroll in the TRICARE Prime or maximize their use of the TRICARE Extra (MCSC, 1996). In other words, the contractor will attempt to encourage adverse selection of the MTFs. It is unclear if the capitation rate will take into account that MTFs are caring for sicker patients or people who use the system more often. It is also difficult to contemplate how the contractor will achieve the desired result. A study conducted between June 1987 and September 1989 hypothesized that health plans were skimming well patients or infrequent users of health care services. It is interesting to note the study found that some of the marketing strategies that we (and others) had hypothesized as related to favorable selection were actually found to be related to selection bias in the opposite direction (Lichtenstein, Thomas, Watkins, Puto, Kepkowiski, Watson, Somone, & Vest, 1992). If that is the case, how can the MCSC be expected to obtain the desired result?

- **Locally developed marketing and education literature should be coordinated with the HSR 3 Lead Agent** prior to mass publication and distribution (MCSC). More than likely this process will slow the individual MTFs ability to respond quickly when necessary.
- Many beneficiaries correlate TRICARE to **declining benefits.** Customers become upset when you "take away" something you appear to have promised. As a result, patients will be offended and their loyalties may shift to the competition (Capko and Anwar, 1996). Organizations, such as The Military Retirees Coalition, which were formed for the single purpose of restoring the promised benefits of lifetime free medical benefits for retirees, have filed numerous law suits and picketed recruiting offices. Beneficiaries of MACH may perceive TRICARE as taking away some of their health care benefits, especially if TRICARE implementation and conversion to a super clinic closely coincide.
- **Marketing dollars** are hard to come by. Every dollar spent on marketing is a dollar that can not be used to provide care or improve the health of the population. Not only is it difficult to obtain a marketing piece of the pie, the pie is getting smaller.
- Organizations have to fight for centrally produced marketing materials. There appears to be an **inadequate number of marketing items** produced to meet the needs of all the MHS health care organizations.

- In several instances the **contractor is required to measure their own behavior.** The contractor provides much of the data used to evaluate contractor performance. It is critical the appropriate checks and balances are in place to identify any potential flaws in the data and keep the contractor "honest" so to speak.

OPPORTUNITIES (SWOT)

- Since **beneficiary education and marketing regarding TRICARE** has been such a problem for most every region, MACH has an extraordinary opportunity to do it right.
- The organization also has an excellent opportunity to **position the TRICARE brand** in such a way that TRICARE Prime with an MTF PCM is a simple and clear theme. There is still an obligation to ensure beneficiaries know all the options; including TRICARE Prime with a civilian PCM, Extra, Standard, and the POS option. The name TRICARE Prime with an MTF PCM should uniquely identify MACH. A theme consistent with the regional concept which is already in place would be to refer to TRICARE Prime at the MTF as "TRICARE MACH."
- **Enrollment-Based Capitation / Revised Financing** will pose both threats and opportunities for MACH. While the MHS's ability to manage risk is suspect; enrollment-based capitation will pave the way for providers to learn to manage the health of a population. There is no blueprint for preparing for capitation, you mainly learn through experience (Health Care Advisory Board, 1994a).

- TRICARE Prime with a MTF PCM is the **low cost option for most beneficiaries.** This provides a significant competitive advantage for the organization. Great care should be exercised not to equate low cost with low quality.
- The **Construction Project** currently under way provides ample opportunity to enhance the physical environment and functionality of the facility.
- By **having to adhere to the same access standards and waiting times as their** civilian counterparts, one of the beneficiaries major concerns regarding the MTF will be eliminated. This improved access coupled with the low cost advantage result in an extremely powerful position, as long as quality is not compromised.
- **Focus on the positive.** TRICARE represents sweeping reform to the way health care is delivered. This type of monumental change may be hard to accept by many; however, we have the opportunity to use the positive things (i.e. readiness, improved access, lower overall governmental cost, etc.) to facilitate acceptance and embracement of this change.
- The ability to **share in contractor financial** gains represents another opportunity. Excessive profits will be computed at a regional level, which would benefit the MHS.
- Because so many service members remain in the force for extended periods (e.g., 10 years or greater) there is an incredible

opportunity to accomplish those long-term issues such as **health promotion and wellness.** Investment on prevention for members and their families could reap great financial and health benefits in the future.

- **Local facilities must think globally.** They have not had to do this much in the past. What is best for the bottom line for the government, not necessarily just for a particular facility, must be the solution. In short, under MCSCs, business case analyses must not only examine the MTF and the downtown cost but the impact on the contract bid price. Even though a civilian facility/provider may be the least cost option, once you determine the bid price impact, the increased contract cost may/may not offset any anticipated savings.
- **Many others are publishing information regarding TRICARE.** This will help stir interest in the program, which will aid in getting the message across to the customer.

THREATS (SWOT)

- **Enrollment-based capitation** offers both opportunities and threats. If enrollment does not meet expectations, funding could be seriously jeopardized. It is also unclear if the capitation rate the MTFs will receive will be sufficient, especially since it is planned that organizations may get additional funding for treating dual eligible Medicare Beneficiaries, tertiary care, and medical readiness and training requirements.

- Under enrollment-based capitation the MTF accepts the risk for their enrolled population. The MTF will be making business decisions based on resources at their disposal. What guarantee is there that **MEDCOM will be able to ensure MACH has adequate staffing and facilities?** For example, if a physician transfers out of the hospital, how timely can a replacement be expected, if ever? Will the replacement be the appropriate grade, specialty, and experience level? How will such actions as civilian hiring freezes, which have been common in past, be handled?
- The **POS option** poses significant threats; especially under enrollment-based capitation. It may prove difficult to manage health and control costs when the beneficiary can access providers without referrals from the PCM's. Hopefully, the significant out-of-pocket expenses placed on the beneficiary will minimize POS use.
- **Data Collection Period (DCP) projections** also pose a threat. If the MTF accomplishes less workload than estimated during the DCP, the contractor will get a bigger payment. Conversely, if the MTF did more than projected, the contractor will get a smaller payment. This threat should be minimized with the advent of enrollment-based capitation. Bid price adjustments should no longer be required or significantly simplified, since most all the dollars will be tied to enrollees. Conversely, tracking transfer payments will create a new challenge.

- **Over-enrollment is a threat.** The entire MHS better deliver what it promises. America Online (AOL), a national internet service provider, is a prime example of the problems over-enrollment can cause. Today's topsy-turvy business world does not excuse a company from offering a product it knows it cannot reliably deliver (Petzinger, 1997). As AOL was eager for market share they offered deep price cuts, publicly admitting they would have trouble meeting the demand. In fact, the strain on the system exceeded the company's worst fears. AOL then hit many of its eight million customers - with an unremitting busy signal instead of the instant communication services it assured them they could count on. Trust is the cornerstone of commerce (Petzinger, 1997).
- An attractive benefit such as **TRICARE may attract more people than the system can cost effectively accommodate,** which could result in increased overall health care cost. This is addressed in the MCSC, marketing materials shall be designed to minimize attracting beneficiaries having other health insurance. The contractor shall identify specific steps to minimize the potential of inducing non MHS-reliant beneficiaries to use MHS resources (MCSC, 1996). There are some two million eligible people who do not currently use military health care (Chapman, 1995). This is yet another requirement for which it is unclear how to accomplish. Tied to this unwanted attraction of beneficiaries, is the possibility of a

reduction in Third Party Reimbursement payments. This simply means people may drop other health care coverage because they are now enrolled in TRICARE.

- By **assigning primary TRICARE marketing responsibilities to the MCSC,** the future of the MHS could be endangered because of under-empanelment. If the contractor does a poor job of marketing the MTF services and patients do not optimally utilize the MTFs, more patients will use contractor provided services instead of the MTFs. At that point, Congress will undoubtedly question the need for the MTFs and, more importantly, their personnel. Providers can ill afford to abdicate marketing responsibility to insurance companies; health plans (at best) are poorly equipped to promote individual providers, while at worst, they may channel lives to competitors. Health plan marketing representatives may not be able to answer basic service questions regarding providers (i.e. office hours). Health plans are often not equipped to promote 'extra' services of individual providers (i.e. on-site pharmacies, toll-free nurse advice telephone lines) (Health Care Advisory Board, 1995c). Under-empanelment could result in the unnecessary assignment of CHAMPUS-eligible beneficiaries to contract network PCMs. This could result in higher contract costs and underutilization of MTF PCMs. Another twist to underenrollment is the traditional death spiral. Some areas of the country have experienced less than robust enrollment, which

makes more space available to treat non-Prime enrollees. As patients realize they can still access the system without enrolling, they do not enroll. This will become even more important under enrollment-based capitation.

- The **Construction Project** poses a significant threat. The disruption and inconvenience to our beneficiaries could prompt them not to enroll in TRICARE Prime with the MTF PCM. They may wait until the project is completed before selecting us. By then it may be impossible to recapture them or enrollment could be so low that staffing was significantly reduced and MACH could no longer accommodate them even if they selected TRICARE.
- From an HMO perspective, **individual enrollment** involves greater insurance risks than group enrollment (Lichtenstein et al., 1992). Adverse selection is a distinct possibility. Since adverse selection is encouraged by attempting to attract the CHAMPUS frequent/high cost users, MACH could be subject to large losses as a result of over-utilization and catastrophic illnesses.
- **Removal of the right of first refusal for the MTFs** is another threat. As with most new endeavors, TRICARE is bound to experience numerous modifications and changes. A potential threat could develop if MTFs are no longer provided the right of first refusal for referrals and specialty care.

- Another change that could steal a competitive advantage is **the leveling of the playing field in regard to co-pays between the MTF and Civilian PCMs.** You buy customers until you end the deal and they stop coming (Tannenbaum and Selz, 1997). If MACH is no longer the low cost option, there is a distinct possibility they will lose enrollees.
- Beneficiary groups are concerned the **DOD will impose limits on enrollment** in the HMO option, reducing access to MTF's for their retirees and their dependents. They limited the number of retirees and dependents who they would impanel. While they have not reached their self-imposed enrollment capacity, they are turning away retirees who wish to enroll in prime with the MTF PCM, as they have met their "retiree capacity."
- The requirement to **share in certain contractor losses** will be accomplished at the regional level. Losses are a distinct possibility based on the projections made by Neil Singer, the Congressional Budget Office's Deputy Assistant Director of the National Security Division. He told Congress the effects of TRICARE are likely to range between additional costs of about six percent to savings of less than one percent; meaning that the Pentagon will save no more than $100 million and could pay an extra $500 million. Another concern regarding sharing these losses is that companies manipulate their earnings. Those that are going to fall short or

that are comfortably ahead save up earnings for next time. Those who expect to come close will borrow earnings from the future. Since companies can and do feed the market what it wants in any one quarter, the result of any single period may be suspect (Lowenstein, 1997).

- **Other methods to provide care** to our beneficiaries are constantly being evaluated and considered. One such method, the Federal Employee Health Benefits Program (FEHBP), is repeatedly mentioned. Several groups, including the Commission on Roles and Missions and the National Military Family Association believe FEHBP would be less costly and more equitable for beneficiaries (Chapman, 1995). Dr. Joseph noted that if an FEHBP option is offered: CHAMPUS eligible beneficiaries who do not currently rely on the government for their health care coverage might be tempted to drop non-government coverage and use government care, thus generating new costs for DOD. He estimated the tab at $500 million a year. He added a parallel circumstance exists for Medicare eligible DOD beneficiaries. Offering FEHBP coverage to DOD Medicare eligibles would require additional new funding for DOD estimated at up to $ 1.5 billion (Chapman, 1996).
- **Overutilizaiton** is another threat. Military beneficiaries have traditionally used health care services some fifty percent more frequently than do civilians in standard fee-for-service health care

plans (Chapman, 1995). Many people throughout the MHS are touting UM as the savior, which is supposed to offset future budget and manning reductions. In order to bring that to fruition, great strides will have to be made to reduce utilization.

- Enrollee **Turnover** is also a threat. It costs five to seven times more to attract new customers than to retain existing ones (Hull, 1996).
- **Better educated patients** who request certain medications or procedures may break the bank. At what point does the financial burden of a therapy outweigh the promised gain? Drug companies are bypassing doctors and HMOs, their usual marketing channels, to appeal directly to millions of consumers (Winslow, 1996). While HMOs tout themselves as champions of wellness that prefer to invest in prevention rather than pay for cures, beneficiaries continue to become savvier. How will the MHS respond to their requests for these medications or procedures?
- **Short term economic pressures** may guide policy on how much to implement health promotion and wellness. Are MHS policy makers and MTFs really creating products and services based on customer needs or are products being created based on what Congress dictates and what is considered affordable?
- **Managed care backlash** poses a threat. As managed care goes from the minority to the majority, managed care organizations (MCO) go from

being the heroes (we save you money) to zeros (they keep us from getting the health care we deserve) (Marlowe, 1997). As the lines between providers and insurers blur, the providers run the risk of being tarred with the same brush as the MCOs (Marlowe, 1997). Consumers start thinking you are the HMO. There are mounting image problems confronting managed care organizations. If marketers don't dispel negative perceptions quickly, a landslide of ill-will could eventually topple the entire system (Clarke, 1995). In the long run, even if it's false, the perception of denial of needed care will hamper HMOs' marketing efforts to attract new members and keep existing ones. If the perception is true, then the HMO should deliver on its promise and provide the type of care for which it is being paid (Clarke, 1995).

- In the effort to control cost we cannot **lose sight of the patients' needs.** Physicians and physician organizations must remain the advocates and protectors of the patients (Lewis, 1995).
- **Part of MACH's image and subsequent enrollment success will be based on the efforts of other MTFs throughout the military.** As personnel transfer and retire, their past health care experiences will impact decisions they will make regarding their medical care. If a beneficiary has a bad experience at Dwight David Eisenhower Army Medical Center (DDEAMC) and then transfers

to MACH, more than likely they will paint MACH with the same brush as they do the DDEAMC. Under enrollment-based capitation these choices will impact MACH's bottom line.

- **Provider backlash** is also a potential threat. Military providers have serious concerns about their workload, MCSC influence, comparisons to civilian providers, and their future in military medicine. After talking with several of the providers at MACH, it became apparent they are suffering from provider backlash. Apparently, providers felt when the MCSC was awarded, their workload would decrease and the contractor would provide additional administrative and ancillary support. They have since determined they may have to work even harder. While MACH contends they have the capacity to take care of everyone in their catchment area, that will not happen if the physicians rebel.
- Many **others are publishing information regarding TRICARE.** Local chapters of military organizations, such as the Association of the United States Army, Noncommissioned Officer Association, and the Retired Officers Association are publishing information about TRICARE. Companies, such as USAA and Armed Forces Benefit Association, are offering TRICARE supplemental insurance and therefore contributing to the massive amounts of TRICARE information being published. MACH has little control or input

regarding what these organizations publish, but will undoubtedly have to respond to what they distribute. To further demonstrate the amount of information that is available, five different search engines were used to search the world wide web about TRICARE. By entering the word "TRICARE" a broad range of "hits" were produced, they ranged from only five hits, using "Yahoo" up to 25,350 hits using "Alta Vista."

- MTF Commanders will designate whether enrollees in the catchment area have MTF or network PCMs (MCSC, 1996). The contractor shall assign enrollees to PCMs in accordance with the Lead Agent and MTF Commanders' determinations. The contractor shall assign enrollees to PCMs at the MTF until the maximum capacity is reached in accordance with the **MTF Commander's determinations,** and assign all other enrollees PCMs in the contractor's network (MCSC, 1996). While this provides an exceptional competitive advantage, beneficiaries may rightfully view this as a method to restrict choice. As a result, they may elect to use Standard or Extra rather than enrolling in Prime.

Objectives and Goals

A variety of visions, missions, goals, etc. are provided for organizations up the chain of command from MACH. These are presented in order to ensure the objectives and goals of the

marketing plan are properly aligned. The goals of this marketing plan support those listed.

Figure 14.

Army

Mission

- Preserve the peace and security, and provide for the defense of the United States. The Territories, Commonwealths, and Possessions, and any areas occupied by the United States
- Support national policies
- Implement national objectives
- Overcome any nations responsible for aggressive acts that imperil the peace and security of the United States

Vision

The world's best army, a full spectrum force trained and ready for victory. A total force of quality soldiers ad civilians:

- A values-based organization
- An integral part of the joint team
- Equipped with the most modern weapons and equipment the country can provide
- Able to respond to our Nation's needs
- Changing to meet challenges of today, tomorrow, and the 21st century

U.S. Army Mission and Vision, 1999

Figure 15.

TRICARE Marketing Plan

Goal

The overarching goal of this marketing program is to communicate the TRICARE benefit so our customers will be educated and responsible consumers. Strategies employed to accomplish this goal will include assisting in product/program improvements to ensure the TICARE health benefit is presented so that beneficiaries who are MHS reliant choose and remain in the Prime option, where available, and fully understand how to access their health care benefit.

Marketing Objectives

- Increase beneficiary awareness and knowledge of the TRICARE benefit so they will be educated and responsible consumers.
- Deliver the TRICARE "new look" across the MHS, integrating print, video, Web/Net, kiosk, conference and other resources to produce a sharp and unified marketing message worldwide.
- Host a customer-driven and market-responsive TRICARE Marketing Conference each year.
- Support MHS Communications, Public Affairs /Legislative Liaison, and Beneficiary/Provider Education staffs—at all levels—to deliver clear, positive, and responsive messages to our diverse audiences worldwide.

TRICARE Marketing Office, 1999

Figure 16.

U.S. Army Medical Command

Mission

Provide medical readiness for the U.S. Army by projecting a healthy and protected force, deploying the medical force, and managing the care of the soldier, the soldier's family, and the extended Army family.

Mission Essential Task List

- Provide trained and ready soldiers to include PROFIS, CTPROFIS, and augmentees to support worldwide contingency operations.
- Maintain cost-effective graduate medical/dental education programs t support readiness requirements. These programs include a military unique curriculum.
- Provide medical, dental, and veterinary services at specified operational sites in conjunction with beneficiary health care.
- Maintain and project the continuum of health care resources required to provide for the health of the force.
- Fully integrate U.S. Army Reserve, Army National Guard Units and individual soldiers as well as other augmentees into the command.
- Provide logistical, acquisition, facility support, and medical research and development to the force.
- Provide education and training to Army Medical Department officers and enlisted personnel worldwide in health care services.
- Teach concepts, doctrine, and exercise systems that provide health services support to the Army.
- Protect and sustain the health and performance of the force through health promotion, preventive, and health care services.
- Receive and treat returning casualties by expanding (as required) health care capacities.
- Promote family support programs.

MEDCOM Fiscal Year Command Training Guidance, 1999

Figure 17.

Southeast Regional Medical Command

Mission

Organize, train, command and control the Southeast Regional Medical Command's medical capabilities so they are ready to support the full spectrum of Army missions while maximizing the health of all beneficiaries.

Vision

The Southeast Regional Medical Command is a world class fully integrated system sustaining a fit force and providing all the medical capabilities to support the full spectrum of military operations while maximizing the health of all beneficiaries.

Mission Essential Task List

- Conduct Mission (Business) Analysis
- Plan Delivery of Healthcare
- Command and Control Medical Units
- Sustain Healthcare Delivery System
- Transition to Wartime Mission
- Reserve Component Integration
- PROFIS Readiness

SERMC Mission Statement, 1998

Figure 18.

Martin Army Community Hospital

Mission

- Provide timely access to quality care in a business environment
- Provide sound, ongoing training and education to staff and patients

Support disaster, contingency, and wartime missions

Vision

Remain customer focused, embrace change, advance the education of our patients and ourselves, and promote excellence in health care and readiness.

MACH Strategic Plan, 1998

A strategy to reach defined goals must be taken from the four basic principles of marketing which are defined in Table 12.

Table 12. BASIC MARKETING PRINCIPLES

Market Penetration	bringing existion products to existing markets
Product Development	bringing new products to existing markets
Market Development	bringing existing products to new markets
Diversification	bringing new products to new markets

(Source: Meyer, 1996)

The MCSC lists specific goals for their performance in the regional marketing plan and will measure attainment of those goals. MACH must also have specific goals of their own. Some of these goals may overlap and MACH may need to monitor the contractors' goal attainment. The success of this marketing plan hinges on three things: education, enrollment, and re-enrollment. Recommended

specific, goals for MACH are provided for each of those three areas.

Goals

Education

- Train 100 percent of MACH's staff on TRICARE by the end of November 1999 (ongoing training will be required after that). CSD staff members will measure this by tracking and documenting all training arranged for or provided.

- The CSD staff will meet with 100 percent of physicians, physician assistants, and nurse practitioners by December of 1999. The CSD staff will measure this by documenting all provider meetings.

- Re-brief all Fort Benning military organizations on TRICARE by the end of December 1999. CSD or RMD personnel have briefed many military organizations on Fort Benning in the past. This needs to be accomplished again and will be measured by CSD staff members who will track and document these organizational briefings.

- Have the CSD staff brief 100 percent of all incoming providers within their first month of arrival at Fort Benning. The CSD staff will measure this by documenting all provider meetings.

Enrollment

- Have 98 percent of Beneficiaries who enroll in Prime, select the MTF as their PCM. (Under enrollment based capitation, leadership will have to demonstrate the courage not to give in to beneficiaries who request a civilian PCM; even if they threaten not to enroll in Prime at all. Those who desire a civilian PCM must be assigned a MTF PCM.) This information shall be collected by the MCSC when performing enrollment. Enrollment forms typically contain a section regarding PCM selection. CSD staff members will obtain this information from the MCSC when obtaining enrollment information each month. It is important the MCSC

inform any beneficiaries who select a civilian PCM, that the MTF will serve as their PCM.

- Actively enroll 100 percent of the active duty population (not in Prime) with a MTF gatekeeper and maintain that level throughout the life of the plan. This will be monitored by comparing enrollment numbers provided by the MCSC to the active duty installation population assigned to Fort Benning (minus trainees) each month.

The following goals refer to MACH's target population. As stated in the management summary, target population is simply the total catchment area population, less active duty, guard, reserves, and Medicare eligible beneficiaries (because those categories are not eligible for TRICARE). Those targets were depicted in Table 1 of the Management Summary of this plan. True target populations are approximately 44,000 each year of the plan. The following formula is used to calculate the true number of impaneled patients at various intervals during the remaining life of the plan starting in option year 4:

Target Population x percent enrolled = Number of Target Population enrolled

Number of Target Population enrolled + Active Duty Members + Guard and Reserve members = **Total Number of Impaneled Beneficiaries**

- Enroll 90 percent of the target beneficiaries at the beginning of option year 4.

  (44,405 x .90 = 39,964.5 members + 15,281 AD + 345 Guard/Res = 55,590.5)

- Enroll 93 percent of the target beneficiaries 6 months into option year 4.

  (44,405 x .93 = 41,296.65 members + 15,281 AD + 345 Guard/Res = 56,922.65)

- Enroll 95 percent of the target beneficiaries at the beginning of option year 5.

  (44,690 x .95 = 42,455.5 members + 15,275 AD + 346 Guard/Res = 58,076.5)

- Enroll 105 percent of the target beneficiaries 6 months into option year 5

  (44,690 x 1.05 = 46,924.5 members + 15,275 AD + 346 Guard/Res = 62,535.5)

Re-enrollment

Re-enrollment will be the ultimate measure of success. The primary means to obtain re-enrollment is by keeping beneficiaries satisfied. The following goals address re-enrollment and patient satisfaction.

- Obtain and maintain re-enrollment at 98 percent throughout the remaining life of the plan (people transferring out of the area

will be excluded). CSD staff members will measure this as they will be interviewing any beneficiaries who disenroll for reasons other than moving out of the area.

- Obtain and maintain 96 percent beneficiary satisfaction ratings throughout the remaining life of this plan. This will be measured through the satisfaction mechanisms in place (e.g., annual beneficiary survey, quarterly survey, MTF telephone satisfaction survey, etc.). Each instrument will be measured separately by comparing the number of respondents to the number of satisfied or dissatisfied to obtain the percentage.

Action Programs

Enrollment

The majority of institutions intensify their open enrollment marketing efforts during the months of September, October, and November as employee coverage typically begins on January first (Health Care Advisory Board, 1995c). While TRICARE enrollment is always open, there will be opportunities since a glut of enrollment should occur at the commencement of health care delivery. According to the Health Care Advisory Board, most successful open enrollment efforts include three features:

1) Aggressive use of tools to reach consumers requiring assistance with plan and physician selection; providers dispensing advice to employees through telephone hot lines,

customized provider directories, high tech computer kiosks and enrollment fairs.

- telephone hot lines provide assistance to assist consumers with selection
- kiosks should be updated daily to provide up-to date information

2) Advertising and promotional campaigns encouraging consumer to choose health plans that include the sponsoring provider.

3) Ongoing work-site education programs to maintain "top of mind " awareness throughout the year; hope is that by going "on site" the provider can create a bond with consumer which will increase the likelihood the employee will choose the provider during next enrollment season. Such programs can be accomplished as follows:

-- Brown bag lunch seminars
-- Free health screening
-- Body fat count
-- Flu shots
-- Vision screening
-- Blood pressure checks
-- Skin cancer checks

(Health Care Advisory Board, 1995c)

Only the best open enrollment initiatives will result in a sustainable competitive advantage. Prospective enrollees are hit

with dozens of advertisements and marketing initiatives simultaneously, so only the institutions with superbly crafted campaigns are initiatives likely to generate more that their natural share of business (Health Care Advisory Board, 1995c).

There are three critical components to the enrollment process. They are education/marketing, branding, and provider selection. Each of the three components is addressed in additional detail below:

Education / Marketing

Both internal and external marketing will need to accomplish the following:

-- focus on customer service, cost, and quality

-- customer focus culture, not department

-- education and marketing for providers, support staff, line commanders, beneficiaries and congressional staff

This marketing plan primarily focuses on MACH Staff (internal) and the beneficiaries we are attempting to enroll in TRICARE Prime with the MTF as their PCM (external). Marketing to providers to include them in the network is beyond the scope of the CSD and will be accomplished by the MCSC. However, the CSD will monitor network adequacy for the benefit of their customers. Other customers such as the congressional staff should receive marketing and education

from levels above MACH; i.e. Health Affairs, Lead Agent, Major Command etc..

Educating the staff will be paramount and buy-in at the local level must be created. As patients hear more about TRICARE they will be asking questions of the health care professionals they encounter. They may or may not seek out experts in the CSD, so it is vital staff members understand TRICARE thoroughly so they do not confuse beneficiaries or spread misinformation.

Branding

In a consumer driven market with many small purchasers, marketing efforts should focus on brand awareness, value driven pricing, distribution (convenience) intensity because success will be achieved one life at a time (Marlowe, 1997). TRICARE is definitely a consumer driven market with many small purchasers, so to speak. In this setting there is a need to create a sense of loyalty among patients. Developing the connection between institutional image, brand name and products is especially important for large integrated delivery systems with many components (Health Care Advisory Board, 1995a).

Much of TRICARE marketing and education has focused on creating TRICARE brand awareness, which consists of three products: Prime, Extra, and Standard. However, there is a fourth product which is elemental to the success and future existence of MACH:

TRICARE Prime with the MTF serving as the PCM (TRICARE Martin). Therefore, it will be critical to the success of the organization to differentiate between TRICARE Martin, TRICARE Civilian Prime, Extra, and Standard.

Brands have distinctive features and benefits that make them valuable to potential customers (an emotional attachment or value). Commodities are virtually interchangeable goods or services that vary on small increments of price (i.e. telephone service, airline travel) (Marlowe, 1997). MTF brand awareness and loyalty need to be created, because organizations that slip into a commodity mode tend to abandon their awareness, preference generating marketing to concentrate on industrial model sales. Once an organization slips into a commodity mode, it is very difficult to ever become a brand again (Marlowe, 1997). An organization can quickly become a provider of a commodity, so you want to sell the beneficiaries the idea that your practice is best suited to meet their needs (Physician's Marketing and Management, 1996b).

Because differentiation is so important, copying the competition will only confuse potential patients. It is important to market a service or product that distinguishes you from the competition. Look-alike marketing tells the patient there is more than one place to go for the service you are selling and you will

have difficulty proving you are a better choice (Capko and Anwar, 1996).

Provider Selection

In addition to marketing/education and branding, provider selection is another key component of enrollment. Basically, potential beneficiaries are being asked to select the MTF as their primary care manager. In order to get people to choose MACH to provide or arrange for their health care needs, it is necessary to understand why people select care givers. It is important to note patients tend to focus on the physician as the most important health care choice they make (Physician's Marketing and Management, 1996b). Civilian marketing studies have shown women make 80% of all family healthcare decisions in America (Health Care Advisory Board, 1995a). Also, 69 percent of people still rely on their family or friends as their primary source of information when choosing health plans or providers (Fromberg. 1997). Many do this because they have a difficult time understanding the information provided, all plans sound similar, or because they do not trust the information provided by employers, who consumers believe are primarily interested in reducing health care costs (Fromberg, 1997). Studies show that consumers consult few sources of information when selecting a doctor (Butler, 1996). There are certain consumer "drivers" listed in Table 13.

Table 13. CONSUMER DRIVERS (Prioritized)

Personal family needs - cost, pre-existing conditions, value-addeds
Access to physician - the ones they want, when they want them
Hospitals available
System simplicity (young families and seniors)

(Marlowe, 1997)

The most critical element of successful strategies is replacing the insurer as the consumer's first point of contact in choosing a physician (Health Care Advisory Board, 1995c). But what it boils down to, particularly in a capitated setting, is providers have to make themselves appealing to the population. Studies show the primary reason for selecting one PCP over another is accessibility, particularly in capitated setting where it is not a money thing at all. Patients are going to pick one doctor or another and the cost is going to be the same. Geographic accessibility to the target population is what is really important (Capitation Management Report, 1995).

Physician Involvement

One of the most important elements affecting enrollment, but the easiest to overlook, is physician involvement. This marketing plan will not be successful without physician involvement and buy-in. Doctors' personal participation in the planning and execution of health care marketing is essential (Koehler and Van Marter, 1995). Studies have shown that about half of all Americans view their doctor as their primary source of medical information -

technical and administrative. Nothing can substitute for the doctor's personal power in marketing communications (Koehler and Van Marter, 1995). For that reason, physicians need to be involved in the entire TRICARE process, including marketing.

For starters, a full time medical director is needed. HMOs with more that 12,000 members benefit from having a full-time medical director. Medical directors typically determine how to manage patients' use of services and make decisions on which practice guidelines the organization will follow (Hudson, 1996).

Physicians should also be used in marketing and education efforts. Use photos of doctors in direct mailings, as a visual image may help make the physician appear more human and compassionate to some patients. One campaign features different doctors in different ads. By rotating him or her, after the campaign is finished every physician will have been quoted. If you constantly feature one doctor in the practice's ads, every new patient that comes in is going to expect to see the doctor who was in the ads (Physician Marketing & Management, 1996a).

Physicians should also be active in the patient relations program. One health plan saw a 31% decline in enrollee complaints within a year after physicians participated in patient relations program (Health Care Advisory Board, 1995c). Individual physicians are best positioned to measurably influence patient satisfaction

and retention; dissatisfaction with the physician is the number one reason for patient defection from managed care plans (Health Care Advisory Board, 1995c).

Satisfaction

Patient satisfaction is another critical success factor in the implementation and marketing of TRICARE. The Annual Health Care Survey of DOD Beneficiaries by Health Affairs concludes satisfaction matters because it helps accomplish those things listed in Table 14.

Table 14. Patient Satisfaction Helps to:

Keep customers and gain new ones
Demonstrate high quality of care
Increase compliance with treatment

(Source: Annual Health Care Survey of DOD Beneficiaries,1997

Basically, when a gap exists between perceptions of quality attributes and outcomes, quality dissatisfaction follows (Hutton and Richardson, 1995). The importance of the service provider creates a situation where every individual in the organization, except one careless service provider, truly intended to deliver excellent service yet a total service failure occurred in the eyes of the consumer (Hutton and Richardson, 1995).

Three underlying themes regarding services are portrayed in Table 15.

Table 15. Service Themes

Service quality is more difficult for the consumer to evaluate than goods quality.
Service quality perception result from a comparison of consumer expectations with actual service performance
Quality evaluations are not make solely on the outcome of service; they also involve evaluations of the process of service delivery.

(Source: Hutton and Richardson, 1995

The Health Affairs Annual Health Care Survey of DOD Beneficiaries indicates there are certain components of satisfaction, which include those reported on Table 16.

Table 16. Components of Satisfaction

General Satisfaction
Technical quality
Interpersonal concern
Finances
Access to appointment
Access to system resources
Choice and continuity

Source: Annual Health Care Survey of DOD Beneficiaries, 1997

There are also costs associated with patient dissatisfaction. The financial costs of dissatisfaction are traditionally viewed as resulting from two sources, which are outlined in Table 17.

Table 17. Finical Cost Sources of Dissatisfaction

Primary cost are based upon the loss of the estimated future profit stream associated with a consumer that has had an unsatisfactory experience and no longer patronizes the organization.
Secondary costs accrue as well. A dissatisfied customer is more likely to spread word of what they perceive as the organization's poor medical services to others. It has been estimated that a customer will tell nine to ten persons a poor experience, more than twice as many persons as will hear about a positive encounter.

(Source: Strasser and Schweikhart, 1995)

Those financial effects of dissatisfaction are far reaching. The returns for decreasing negative word-of-mouth effects can be anywhere in a possible range of $6,000 to $400,000 (Strasser and Schweikhart, 1995). The "value of higher patient opportunities, satisfaction, and increased loyalty extends beyond retention to new business many consumers rely on peer recommendations when choosing plans and providers (Health Care Advisory Board, 1995c).

Word-of-mouth communication affects the success of almost any health care (Gelb, 1995). Health care providers may benefit from word-of-mouth communications when it is favorable, or be hurt by it when it is unfavorable. The absence of word-of-mouth communication can also be harmful. Word-of-mouth is more effective than advertising. Word-of-mouth increases awareness and knowledge, but it also persuades and leads to action, such as actually choosing the provider one has heard about. Unfortunately, favorable word-of-mouth communication cannot overcome personal negative

experience. Personal sources of information, specifically word-of-mouth, have a more decisive effect on the purchase decision than do commercial sources of information, such as advertising. The effectiveness of word-of-mouth is diminished when prospective buyers have some prior impression of the brand of interest, or when negative information is presented as well. It might be better to provide "OK" service to four patients than "good" to three but "poor" to one. A training dollar spent inspiring warmth in patient-contact personnel can be worth more than a dollar spent on equipment if favorable word-of-mouth is the goal (Gelb, 1995).

Two common forms of measuring patient satisfaction are surveys and customer complaints. Complaining to others is more likely when it is difficult to complain to the organization that caused the perceived problem (Gelb, 1995). However, most patients who are dissatisfied will not say anything, except to their friends and coworkers. Patients who do fill out questionnaires often do not express their true feelings. Experience suggests that on a 1-to-5 scale, even the least successful practices will rate 4.5+ on "quality" because no patient wants to believe that he or she has not selected the premier physician in the area (Lewis, 1993).

A survey will create expectations, so only ask questions about areas you can fix (Hull, 1996). That may or may not be possible; however, an important desired result is willingness to return and

willingness to recommend (Hutton and Richardson, 1995). It is also important not to hide bad results, but mention a corrective plan and tout your improvements and corrections (Marlowe, 1997). One method to improve satisfaction is to reduce the administrative barriers to receiving care. Consumers are far more interested in convenience for their health services than in becoming familiar with the inner-workings of the hospital (Health Care Advisory Board, 1994).

Health Promotion

More than 90 percent of each health care dollar is devoted to curing illnesses that account for 10 percent of preventable deaths. Waiting until the illness becomes overt squanders time and opportunities to prevent disability, and at the least, to reduce productivity (Health Care Advisory Board, 1995c). Accordingly, heath promotion, disease prevention, and wellness are all vital to the long-term success of TRICARE.

Predictable illness, in fact, account for only about an eighth of the healthcare services distributed in any one market (Profiles, 1996a).

> Building a healthier community does not mean simply ensuring the absence of disease. Nor is it limited to restoring wellness by curative intervention. Instead, it means preventing illness and injury while protecting our environment. This is the path to increasing the "whole health" (physical, mental, and spiritual) of the population. Achieving higher levels of health requires individual commitment. It requires full command and family involvement. The Army must develop a health conscious culture

that encourages fitness and exercise, healthy eating habits, continuous learning, increasing self-awareness, and consideration of others and the environment. The culture must discourage self-destructive preventable risk factors such as smiling and substance abuse. Facing these challenges demands the collaborative efforts of commanders, medics, Family Support Centers, chaplains, and other support services (Profiles, 1996a).

Blaming the victim must stop and marketing efforts need to address individuals and encourage individual behavioral change, thus implicitly holding individuals responsible for the solutions to problems (Ling et al., 1992). Commercial companies often drop a product line when products prove unpopular. It is more difficult to discontinue a needed public health service (Ling et al., 1992). It is also important to understand this type of social change is a complex and challenging process (Ling et al., 1992). To be successful, education in marketing materials must be emphasized. If (consumers) don't understand why preventive care is important, they won't want to be involved in these programs (Profiles, 1996c). These behaviors involve areas such as: fitness, nutrition, stress-management, sexual practices, alcohol, and drug use.

Health promotion strategies focus on environmental and regulatory measures that involve protection of populations. These strategies focus on avoidable injuries, occupational safety and health, environmental health, food and drug safety, and oral health. These programs empower individuals and groups to increase

their control over and improve their health status by expedient use of a combination of health education and related organizational, social, economic, spiritual and health care interventions. Unfortunately, the American population is not always interested in being told how to live their lives (Marlowe, 1997). Regardless, the U.S. Department of Health and Human Services national Putting Prevention into Practice campaign recommends the mechanisms listed in Table 18.

Table 18. METHODS TO PUT PREVENTION INTO PRACTICE

Age/gender specific services
Risk reduction counseling
Immunization
PCMs
Clinical preventive services
Behavior/lifestyles

(Source: Putting Prevention into Practice, 1999)

Providers must recognize that every patient encounter should be used as an opportunity for preventive care.

It must be remembered that a comprehensive, relevant preventive service and health promotion program is a significant part of a total, cost effective, quality healthcare plan. A firm commitment to preventive medicine and health promotion is essential for all health care interactions in the MHS, regardless of setting. To put it simply, if people are healthier, they won't need as much medical care. A healthier force not only reduces the need -- and

cost -- of health care, better health increases force readiness (Gillert, 1996).

There are specific components of health promotion, disease prevention, and wellness. These include nurse advisory telephone lines, self-intervention books, health screenings, and work-site screenings. Only 10 to 14% of a given healthcare population will call a nurse line during the course of a year (Profiles, 1996a). Payback grows when more people call, but the trick is to convince as many people to call a nurse line as possible. Calling a nurse instead of a family physician is not an intuitive thing, so there is a bit of education to get people to try it. The initial reaction is, you're trying to keep me away from the doctor's office or you're putting me off (Profiles, 1996a).

Work-site screenings have also become in vogue primarily because screening programs positively influence the public's perception of their hospitals (Health Care Advisory Board, 1994). Major marketing benefits of custom-made work-site screenings are characterized in Table 19.

Table 19. Marketing Benefits of Work-Site Screenings

Reduction of utilization cost by improving health of a significant portion of the community
Increased public awareness of the services provided by the hospital

(Source: Health Care Advisory Board, 1994)

Re-enrollment

Customer retention is the ultimate measure of successful service (Lewis, 1993). Enrollee dropout continues to be a challenge in the health care industry. The enrollee dropout rate is 20 percent in United States managed care plans (Marlowe, 1997). Once the desired level of enrollment is attained, those customers need to be satisfied to ensure they stay. Health care organizations are beginning to ask, if 95% of enrollees say they are very satisfied with my group, why do I have 11% disenrollment rates? (Health Care Advisory Board, 1995c).

The importance of relationship management will only increase over time; as managed care penetration increases, it will become more difficult to rebound from defections by attracting new patients (Health Care Advisory Board, 1995c). Improved retention rates are likely to have some "spillover" benefit in generating new business, as patients recommend physicians to friends and acquaintances (Health Care Advisory Board, 1995c). Russell Coile summed it up when he said, you get customers on price, but keep them with service (Coile, 1996).

Minimizing enrollee defections is key to profitability (Health Care Advisory Board, 1995c). There appear to be five key steps which can minimize defections. These steps were taken from a variety of sources and are described in Table 20.

Table 20. Process to Encourage Retention and Minimize Defections

Invest in open enrollment marketing; at a minimum, such activities protect existing patient base, while at best, will-constructed campaigns yield substantial increase in market share. Best way to influence large number of consumers who switch health plans...is to reach them at the point of decision; providers uniquely positioned to convey advantages of their organizations to employees, who are highly receptive to information on health care providers during open enrollment season (Health Care Advisory Board, 1995c).
Your best opportunity to stimulate practice growth and new patient retention depends on how a patient is handled during their first encounter. Marketing cost and efforts will be ineffective if a patient is disenchanted when they are seen in the office (Capko and Anwar, 1996)
Quick resolution of member complaints is important to reducing defections. Similarly, take these complaints seriously, because disenrollees were three times more likely to claim that their doctor did not take their complaints seriously. Those who complain about medical matters disenroll voluntarily at more that four times the rate of non-complainers (Health Care Advisory Board, 1995c).
Actively contact potential re-enrollees 30-45 days prior to re-enrollment period. Track enrollee utilization and within legal limits, provide value-added to low users to encourage re-enrolment. Follow re-enrollment with a member kit and a hank you (Marlowe, 1997).
Personally interview all members who disenroll in attempt to reverse decision; evidence from other industries suggests that many voluntary defections can be reversed through prompt recovery efforts, resolution of service complaints (Health Care Advisory Board, 1995c).

Communication Effectiveness

Regardless of how well previous five critical success factors are accomplished, if communication is not properly accomplished, failure is almost sure to follow. The following methods apply to health care marketing, education, and communication efforts.

Consumer's choice becomes more difficult if the information used in making the decision is not presented in a useable and

processable format. The mere availability of information does not ensure that it is understandable and useable by consumers in the decision making process (Butler, 1996). There are four qualities of information which determine if it can be used in consumer decisions and they are provided in Table 21.

Table 21. Information Qualities Which Can Be Used by Consumers in the Decision Making Process

Available
Useful - should supply new discernment about the characteristics of the services what will help the consumer decide if these characteristics are desired or helpful
Processable within the time, energy, and comprehension level of the consumer
Well-formatted - should be not only processable but strategically placed for the decision making situation within the required time frame without confusion

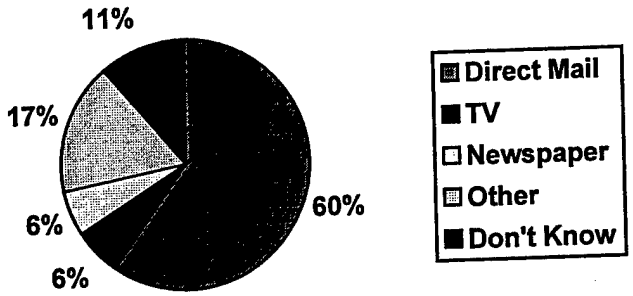
(Source: Butler, 1996)

Health-conscious consumers want relevant information presented in a meaningful and intelligible form. People are bombarding the marketplace with different types of information. Information communicated to the public must be even more clear and direct. We overestimate the average consumer's ability to consume the information we give them (Fromberg, 1997). Successful advertising most often is simple, direct, and hard hitting (Samuels, 1993). Americans prefer to receive health care information by direct mail rather than television or newspaper advertising, according to an anonymous survey published in Hospitals. The results of the survey are illustrated in Figure 19. Further, print ads are most

effective when they feature a mug shot of the physician rather than just his name (Physician's Marketing and Management, 1996b). Others contend it is better to work through existing distribution channels, rather than going directly to the patients (Koehler and Van Marter, 1995). While some claim that an educational approach may work best, rather than using advertising or direct marketing. Koehler and Van Marter believe that educational articles are more credible, accurate, and timely than advertising (Koehler and Van Marter, 1995). Given that, it is important to realize, personal contact has a greater impact than other kinds of marketing (Physician Marketing and Management, 1996b).

Figure 19.

Americans Preference for Receiving Health Care Information



(Source: Hospitals, 1992)

Health care marketers have a moral obligation to use resources wisely, since any money spent on marketing are funds not available for clinical services (Hull, 1996). Unless market research is performed, hospitals run the risk of plunging a lot of money into a campaign that may not prove effective. Today's leaner hospitals must maximize their return on investment in marketing. They cannot afford to waste resources by communicating with the wrong audiences (Health Care Advisory Board, 1995a).

Measurement

To determine if the marketing plan is successful some type of measurement will be needed. This information is provided in addition to that provided in the goals and objectives section of this marketing plan. Performance measures can be divided into four equally important categories: satisfaction, clinical outcomes, functional health status, and total costs (Fromberg, 1997). These relate closely to the critical success factors previously mentioned.

Satisfaction currently receives the most attention, with clinical outcomes and health status still lagging behind. Managed care consumers vote with their feet. A successful plan or provider must identify what satisfies consumers. Specific satisfaction measures include: access, communication, and administration. Satisfaction measures must pinpoint factors that contribute to

customer loyalty, including a customer's willingness to promote a particular health care plan or provider. Most health care organizations worth their salt have a whole sheaf of great results in survey files, results that say 95 percent of their patients or members are satisfied or very satisfied. However, some of those satisfied customers will leave for a savings of six or eight dollars per month. Current measures of health plan's clinical care tend to focus on prevention rather than clinical outcomes. In the future, the true measure of health plan or health care provider's effectiveness will be its ability to manage the health of defined population (Fromberg, 1997).

Methods to measure the effectiveness of specific advertisements directed toward customers are included in Table 22. This may be extremely useful during initial enrollment the first sixty days prior to TRICARE commencement. The ultimate indicator of success after initial enrollment will be re-enrollment of beneficiaries (adjustments will have to be made for those who transfer out of the area).

Table 22. Methods to Measure Advertisement Effectiveness

Conduct focus groups to measure appeal of advertisements
Survey consumers/employees to determine awareness of hospital
Survey consumers/employees to determine top-of-mind recall of hospital
Track number of enrollees, admissions, and discharges for the specific programs advertised
Track number of calls received after direct mail campaign for specific programs
Measure patient volume for the hospital and for specific programs, both before and after image advertisements are run

(Source: Health Care Advisory Board, 1995a)

Other means to measure marketing plan objectives are provided in Table 23.

Table 23. Additional Means to Measure Marketing Plan Objectives

Narrative critiques following briefings
Patient questionnaires
Special event evaluation forms
Customer feedback to patient representatives
Percent of staff and beneficiaries educated
Percent of TRICARE Prime enrollees with TRICARE Martin

The success of any education plan is a function of the resulting change in practice and behaviors. Assessment will be an ongoing process. After the marketing plan is put into effect it will be important to evaluate and assess the plan as a whole. Along those same lines the quality of the beneficiary and provider briefings needs to be monitored and continually evaluated. Other

measurement means include the metrics the MCSC uses to monitor the affects of marketing. How is the information obtained? What does it mean? Why was a particular indicator selected to measure success? Are there better methods or metrics to get the data?

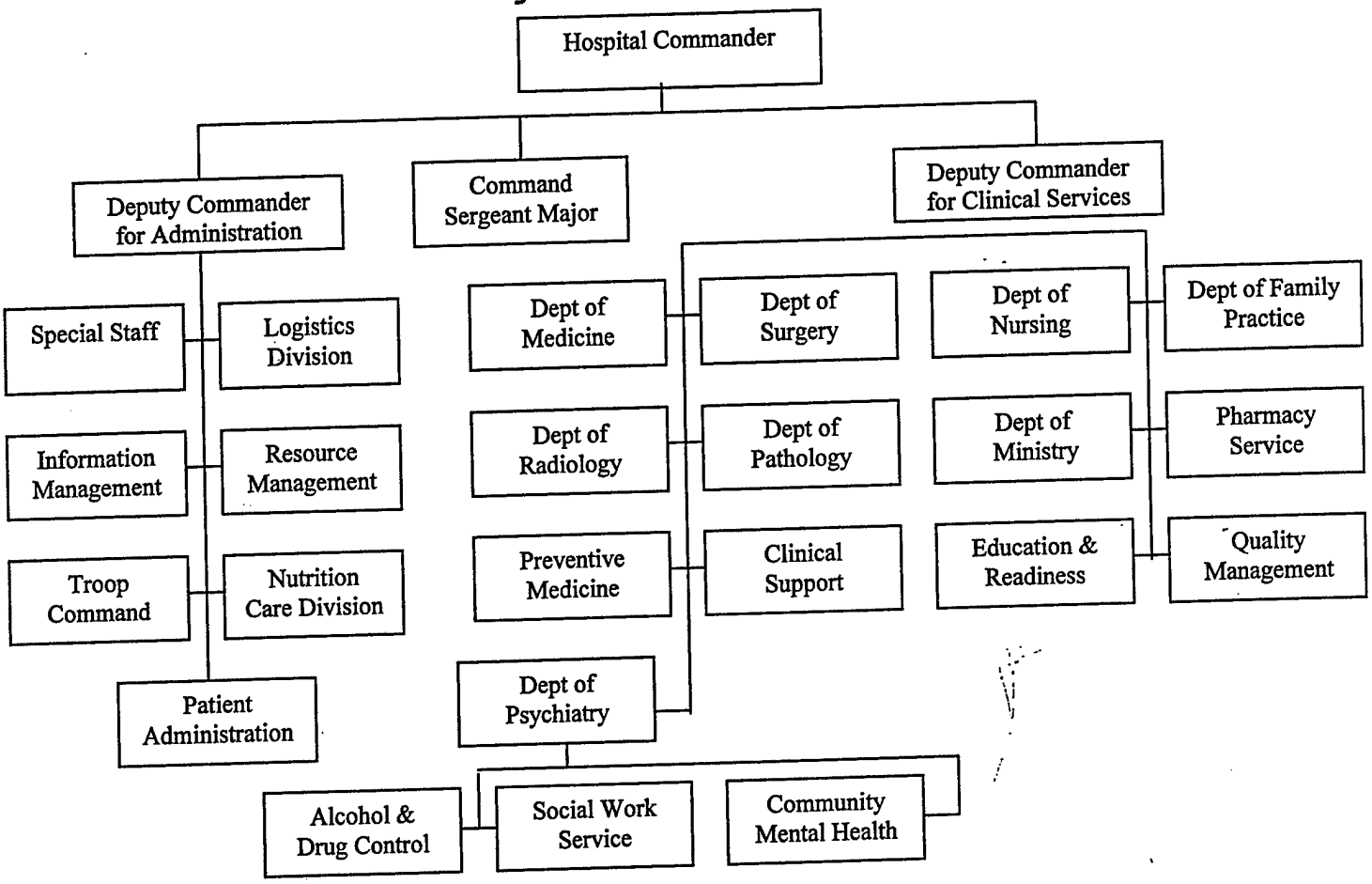
Action Plan and Responsibilities

This section is the heart of the marketing plan. It identifies the actions that should be taken and who will be responsible to ensure they are accomplished. It has been well documented that health care is a local endeavor. It makes sense that marketing of health care can best be performed at a local level, rather than solely at a regional level. Because healthcare is a product bought and consumed locally, national marketing strategies won't work in every market (Firshein, 1996). However, past social marketing techniques identified that national campaign strategies and materials have important benefits for state or community programs. National campaigns are typically enriched by creative strategies developed at the local level (Samuels, 1993). While the MCSC will use a regional strategy, it should definitely support the community or "local level" marketing efforts and vice versa. This plan takes those regional efforts and national efforts conducted by the TMO and others and tailors them to the needs of MACH.

There should be a qualified person in charge of the marketing function in the organization who interacts closely with all divisions of the hospital, reports to the hospital commander, and participates in management decision making. Without organizational and top management support, marketing cannot perform (Naidu, Kleimenhagen, and Pillafi, 1992). The Chief, CSD (C, CSD) will be responsible for the overall marketing function for MACH and will be the liaison between the MCSC and MACH regarding TRICARE matters, including marketing. The C, CSD reports to the Deputy Commander for Clinical Services, who reports to the Commander. The MACH organizational chart is at Figure 20.

Figure 20. **Martin Army Community Hospital**

Organizational Chart



The DOD TRICARE Marketing Plan lists roles and responsibilities for many DOD organizational elements. Those roles and responsibilities are synopsized below.

OASD-HA has overall responsibility to ensure the success of TRICARE through operational, procedural, financial, and marketing activities. OASD-HA ensures the marketing plan's objectives are communicated to DOD leadership and requests their full assistance, support, and cooperation. OASD-HA will also ensure activities required to implement this plan have command sponsorship, are

supported at every level, and are fully funded. They will also ensure the entire MHS staff is educated, informed, and trained to advocate TRICARE by establishing TRICARE and customer relations training at every level for the military medical community (DOD, 1998).

OASD-HA TRICARE Marketing Office (TMO) is responsible for advising OASD-HA, the Uniform Services, Lead Agents, and OCHAMPUS regarding the marketing of TRICARE. The TMO researches, prepares, and coordinates the implementation of a DOD program to educate and inform beneficiaries and providers worldwide regarding all aspects of TRICARE. They have overall responsibility for promotion, education, information, and market research activities for TRICARE. The TMO will also develop briefing materials for educating target markets and information/educational materials for distribution to the Uniformed Services and Lead Agents for both providers and beneficiaries (DOD, 1998).

Uniformed Service Chiefs are requested to:

1. Make TRICARE education a top priority.

2. Ensure service public affairs officers productively pursue full dissemination of TRICARE information to all audiences.

3. Ensure installation/unit commanders are aware of the MTF commanders' responsibility to coordinate a TRICARE briefing program for all service members.

4. Encourage installation personnel officers to assist in coordination of this program (DOD, 1998).

OASD for Public Affairs (OASD-PA) has the overall DOD responsibility for informing and education all service members and their families about anything that affects their personal or professional welfare (DOD, 1998).

OASD for Force Management and Policy (OASD-FM&P) will coordinate with the services to implement TRICARE education at various military transition points; to include: enlistment, basic training, commissioning, reassignment, retirement, etc. They will also coordinate with Defense Finance and Accounting to use the Leave and Earning Statement to disseminate TRICARE educational information provided by the TMO (DOD, 1998).

Offices of the Surgeons General are responsible for coordinating and overseeing the dissemination of TRICARE information throughout their services (DOD, 1998).

Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) serves as the authority on MCSC contract compliance. The Public Affairs and the Liaison Branches of OCHAMPUS, in Collaboration with the TMO, will maintain and control all TRICARE Standard activities within the TRICARE regions (DOD, 1998).

Managed Care Support (MCS) Contractors and their regional Lead Agents have the primary responsibility for planning and execution marketing strategies to clearly present the TRICARE program and to encourage beneficiary enrollment in TRICARE Prime in their respective health care regions. They are also obligated to conduct provider training on TRICARE and managed care in accordance with contract provisions.

Lead Agents are responsible for oversight of MCS contractors' marketing programs, including both program marketing and provider education and training conducted by the contractors. In those areas where beneficiaries are offered choices of military or civilian network PCMs the benefits of choosing the military facility/PCM must be convincingly presented to eligible personnel (DOD, 1998).

MTF commanders are responsible for developing and coordinating the MTFs public affairs and TRICARE marketing programs within their catchment area. MTF commanders should:

1. Ensure the installation commander and staff are briefed and knowledgeable about all aspects of the TRICARE program, enrollment, and implementation.

2. Coordinate an annual TRICARE briefing for every active duty service member, unit, retiree, and all family members within the catchment area.

3. Implement an intensive training program to ensure the MTF staff is thoroughly knowledgeable about every aspect of TRICARE.

4. Initiate proactive customer relations for MTF staff to ensure they are positive representatives of the MTF, MHS, and TRICARE.

5. Consult with Lead Agent regarding TRICARE marketing. Provide marketing, managed care, and health benefits representation to the regional marketing committee/working group.

6. Develop proactive speakers bureaus to coordinate briefings/presentations for local veterans groups, military and retiree organizations about TRICARE, and upcoming changes in the MHS (DOD, 1998).

Installation Commanders have overall responsibility to ensure all their active duty personnel and family members are informed of anything that affects their personal or professional welfare. The following actions are requested of <u>installation commanders</u>:

1. Ensure command and staff are thoroughly briefed by MTF commander or staff officer about all aspects of TRICARE enrollment and implementation.

2. Support MTF commander's TRICARE briefings.

3. Ensure the installation public affairs office is an active participant in the Regional TRICARE marketing/public affairs working group (DOD, 1998).

Armed Forces Public Affairs Offices have primary responsibility for educating and informing their service members, retirees, and family members about all aspects of TRICARE (DOD, 1998).

Options Available

There are a plethora of methods available to accomplish marketing, education, and communication objectives. Those listed in Figure 21 should be used as a starting point to spark other ideas, and is far from all-inclusive.

Figure 21. Marketing/Communication Education Methods

Advertising	Spokesperson	Community Meetings
Provider Handbooks	Publicity	Direct Mail Anecdotal campaigns
Annual Report	Newspapers	Billboards
Public Service Ads	Slide Shows	Education
Internet (Home Page)	Television	Displays
Radio	Market Research	Health Fairs
Coupons	Inserts	Workspace Safety Audits
Personal Contact	Trinkets	Report Cards
E-Mail	Newsletters	Posters
News Release	Pamphlets	TV/Radio Interviews
Fact Sheets	Civic Organizations	
Professional Staff Meetings		Commander's Call

All media forums available will be used to support the marketing and education aspects of the TRICARE Program. Care must be taken because governmental agencies have certain restrictions

regarding promotional items. For instance, governmental funds cannot be expended on promotional items (e.g., trinkets, pens, mouse pads, coffee cups) (Whitaker, 1997). That does not prohibit encouraging the MCSC to purchase such items. Purchasing radio or television advertisements may also be a challenge. Once the broadcast media have been paid to air public health spots, they are no longer willing to give free air time (Ling et al., 1992). Deviation from the standard presentation for the purpose of targeting specific catchment areas is encouraged; however, Lead Agent coordination is necessary to ensure continuity of the message within the region.

Regardless of which methods are used to relay the TRICARE message, the message must be consistent. The information must be simple, clear, and direct. Even more importantly, the information should be presented at the appropriate level. In other words, do not overestimate the target audience's knowledge of the material. Furthermore, information must be accurate, brief, concise, and clear. The material must emphasize the positive, yet honestly address all the information. Positives that should be emphasized are the future "newly" remodeled Emergency Room, Acute Care Clinic, Women's Health Center, the myriad of health promotion activities offered, the low cost of our option, and repeatedly emphasize our quality of care. Everything published should also tell the

beneficiary how to contact the CSD to get more information, discuss concern, or answer questions.

Actions

This marketing plan is for the three year time period beginning in June of 1999 and ending in May of 2002. Within the following section, tables are provided that identify necessary actions, their frequency, and who is responsible to accomplish those actions. There are certain marketing actions that need to occur prior to the implementation of this marketing plan and they are listed in Table 24.

Table 24. Initial Marketing Actions

Responsible Organization	Action
MTF - CSD	Initiate briefings to ensure every Fort Benning military organization is briefed by the end of September 1999.
MTF - CSD	Conduct one-on-one sessions with all MSCH physicians, physician assistants, and nurse practitioners to rally support for TRICARE and address their needs and concerns.
MTF - CSD	Establish briefing schedule at convenient times, various times, in various locations which are well publicized, so every eligible beneficiary has the opportunity to attend a session.
MTF - CSD	Conduct MACH staff training.
MTF - CSD	Establish a "mock patient" or "shopper" program to monitor process effectiveness.

Providers need to be assured through TRICARE they can learn the skills necessary to manage the health of a population without risk to their personnel income, as their civilian counterparts are

experiencing. The military no longer offers a guaranteed military career; yet providers can learn the skills that will make them employable throughout a lifetime. The C,CSD should be able to relay this message to the military providers by meeting with each of them.

Tables 25, 26, 27, 28, and 29 define the marketing actions necessary by frequency.

Table 25. Monthly Marketing Actions

Responsible Organization	Action
MTF - CSD	Submit articles for publication to the MTF and Post newspaper.
MTF - Chief Information Management Division	Ensure the MACH homepage is up-to-date, to include current TRICARE information,
MTF - Chief Information Management Division	Ensure MACH telephones with hold capabilities include current TRICARE messages.
MTF - CSD	Submit TRICARE information to the post cable channel.
MTF - CSD	Submit TRICARE information to the post bulletin, local civilian paper, the post retiree coordinator's office etc. as appropriate.

The C,CSD shall establish relationships with personnel at the Post Newspaper and with the SERMC marketing office to ensure any articles submitted for publication are first coordinated with the MTF. The relationship with personnel at the post newspaper will be

important to continually ensure this information gets published even after the newness of the marketing plan dissipates.

Table 26. Quarterly Marketing Actions

Responsible Organization	Action
MTF - CSD	Conduct focus marketing questionnaire to eligible beneficiaries.
MCSC	Distribute provider bulletins.
MCSC	Distribute provider newsletters.

The CSD must evaluate the results of the focus marketing questionnaire each quarter and make adjustments to this plan.

Table 27. Semi-Annual Marketing Actions

Responsible Organization	Action
MCSC	Conduct provider education session.
MCSC	Conduct general information session.
MTF - CSD	Review this marketing plan and make necessary adjustments.
MTF - CSD	Met with all receptionists and technical who have extensive patient contact to monitor patient attitudes

The CSD will monitor general information and provider education sessions performed by the MCSC to ensure any incorrect information that may be presented can quickly be dispelled and to allow for contract compliance monitoring. Receptionists and technicians who have extensive patient contact can provide excellent information about patient attitudes and perceptions. These staff members need to be brought into the fold and their

customer knowledge needs to be tapped. The C,CSD will meet with these folks initially, then every six months to help capture the customer's pulse.

Table 28. Annual Marketing Actions

Responsible Organization	Action
OASD-HA	Conduct the annual beneficiary survey.
MCSC	Submit the Regional Marketing Plan to the Lead Agent for approval.
MTF - Deputy Commander for Nursing	Conduct a health fair

HA is attempting to accomplish the beneficiary survey on an annual basis. The process has taken 18 to 24 months in the past, but HA will now attempt to compress it into a 12 month span. They sample 170,000 adults and 30,000 children. Beneficiary category and catchment area stratify the adult sample. The child sample is restricted to overseas. The results are returned to the services and regions. The C, CSD needs to obtain a copy of the results of this survey each year and make necessary changes to this plan, based on the results.

Health fairs need to be coordinated with the MCSC and C,CSD, so TRICARE enrollment can be accomplished at the same time.

The C,CSD shall obtain a copy of the Regional Marketing Plan prior to its approval each year and provide necessary feedback to the Lead Agent, so appropriate changes may be made.

Table 30 outlines ongoing marketing actions that will need to occur.

Table 29. ONGOING MARKETING ACTIONS

Responsible Organization	Action
MTF - CSD	Meet with all providers newly assigned to MACH to rally support for TRICARE and address their needs and concerns.
MTF - CSD	Conduct ongoing TRICARE education for the Command group.
MTF - CSD	Ensure the CSD is represented at medical staff meetings to address provider's questions and concerns, as well as solicit provider support.
MTF - CSD	Utilize the Health Consumer Advisory Council, which should have representation from most military organizations on Fort Benning, to monitor the pulse of the beneficiaries and address TRICARE issues.
MTF - CSD	Personally interview (this can be accomplished over the telephone) all beneficiaries who disenroll from TRICARE for reasons other than they are moving from the area.
MTF - CSD	Monitor MCSC marketing and education efforts.
MTF - CSD	Conduct and monitor staff TRICARE training and education.
MTF - CSD	Ensure all new Prime enrollees are welcomed with a thank you letter from the Commander, which also provides a point of contact at the facility to answer any questions beneficiaries may have. This should be coordinated with the MCSC and this thank you letter could be included with the information the contractor sends to the new enrollee.

MCSC	Place TRICARE information (i.e., brochures, pamphlets) in high traffic areas (e.g., commissary, exchange, MTF) on Fort Benning. There may be occasions when MACH feels it is necessary to perform this function to get particular information to the beneficiary population. The CSD should attempt to get the contractor to perform this function prior to accomplishing it themselves.
MTF - CSD	Actively contact potential re-enrollees 45-75 days prior to renewal. More than likely the MCSC will also accomplish this by sending renewal packages. The CSD will supplement this action with either a letter or preferably a telephone call to determine if the beneficiary has any questions or need any assistance in the process. This will required close coordination with the MCSC to determine when enrollees are due for renewal.
MTF - Commander	Take advantage of every opportunity at post meeting with the installation commander and other leaders on Fort Benning to keep them informed about TRICARE and sell its positive aspects.

CSD personnel will have key relationships to build and maintain. This process will be ongoing. Some of the key relationships include: MCSC staff, MACH command group (Commander, Deputy Commander for Administration, Deputy Commander for Clinical Services, Deputy Commander for Nursing, etc.), TMC points of

contact, Patient Affairs Liaison staff, UM staff, Lead Agent, Post Public Affairs, etc.

CSD personnel will monitor MCSC marketing and education efforts. They will evaluate differences between what was proposed and what actually is being provided. An attempt will be made to be included in the review of these materials prior to publication to ensure the message is consistent and accurate. Also, CSD personnel will be represented at briefings or educational sessions the MCSC provides in the MACH catchment area. This may be relaxed after confidence is developed in the briefers and their message. Monitoring and evaluation will continue, but it may be of the random, spot-check, type.

Staff training will be an ongoing process and is primarily the responsibility of the CSD. This can be accomplished through a variety of mechanisms. Presentations could be given to the entire organization as a whole or staff members could be required to attend information sessions being held for the beneficiaries. Every member of the organization will need this ongoing training. Volunteers, Dental Clinic personnel, and any others who are not actually housed in the MTF but are a member of the organization should be included.

All mailings to beneficiaries should be coordinated with the MCSC and Lead Agent so they may be piggybacked on other mailings

that are being sent and to ensure accurate and consistent information is sent. CSD staff members need to be flexible enough to be able to develop and offer topic specific briefings at the request of beneficiaries or any identified need. This may require bringing an expert from outside the area to perform the briefing.

Formal written beneficiary and provider surveys will not be administered by the CSD. Between the Annual HA survey and the focus marketing efforts, there is a potential risk to survey MACH's beneficiaries too much. Additionally the DOD requires all surveys to be approved prior to use and the process is extremely cumbersome. The CSD can monitor customer satisfaction by using the information obtained from those surveys and through focus groups, the Health Consumer Advisory Council, the Fort Benning BOSS Line, and the existing patient complaint process. Other methods to monitor satisfaction and better understanding beneficiary needs include: conducting periodic sessions with the receptionists and technicians who deal with these patients. They can provide a unique perspective that is often overlooked. Another method is to have CSD members serve as mock patients; however, they need not be mock patients. Task the CSD members to constantly scrutinize the processes they encounter when they or their family members obtain care. A one-page form should be developed to document the results. After this is established it could be spread well beyond CSD

personnel and basically anyone could serve as a mock patient. Critiques and feedback forms shall be utilized for every briefing, which should also provide an insight into beneficiaries needs, wants, and level of satisfaction. We want to monitor satisfaction over time and possibly compare it between PCMs.

At a given post there is typically a handful of progressive providers willing to try new things and demonstrate an eager enthusiasm about their profession. Normally, these folks are younger and less experienced, but not always. The C,CSD will identify these trend setting individuals during the one-on-one sessions and attempt to involve them in the TRICARE marketing process, as well as all TRICARE endeavors. Hopefully, as other providers witness the great things they are missing, they will seek out these individuals and learn from them.

The C,CSD should continually monitor the pulse of TRICARE in regions that have been operational for a period of time, so they can anticipate problems and proactively address them.

Miscellaneous Ideas

Most patients are comfortable with their physician, but uncomfortable with the administrative barriers and paperwork that hinder their physician's efforts to properly care for them (Lewis, 1995). In that spirit the following ideas, while not specifically

marketing related, could improve service, efficiency, convenience, access, quality or reduce cost and should be considered:

- The Deputy Commander for Clinical Services will function as the medical director. While this should not represent a change in operations, the medical director must take this role seriously and not function as a "rubber stamp." The medical director must implement best practices and clinical pathways to both improve efficiency and quality of care. The Deputy Commander for Clinical Services will also be crucial to obtaining TRICARE buy-in among the professional staff. This individual must believe in TRICARE and must be able to pass that on to the staff. Physicians will be required to change practice patterns and the medical director must facilitate that change.
- Provider templates and appointment schedules should be easily modified to address seasonal needs. In the summer, there should be ample back-to-school or sports physicals available. During cold and flu season, more same day appointments may be necessary. These needs should be constantly monitored by looking at demand and making the necessary modifications.
- A creative way to offer service guarantees should be explored. Service guarantees are a vogue method to demonstrate your commitment to customer service. McDonald's restaurants considered offering service guarantees. The policy was to

state: customers will receive their orders within 55 seconds of placing them, or get a coupon for a free special sandwich (Gibson, 1997). Even though the policy was partially implemented, then quickly stopped, the thoughtful use of service guarantees can raise morale, channel complaints that might otherwise go to the "wrong" people, and provide a unique marketing edge (Lewis, 1993). While money will more that likely be out of the question, some type of creative incentive should be developed.

- Staff members need to become more flexible. For example, some administrative positions may need to be trained so they can work appointment lines during peak periods. Conversely, appointment clerks can also be trained to perform other functions during slack periods.
- MACH should consider offering day care for patients with small children. This would enable patients to leave their children while they obtain care. This could be accomplished through some type of arrangement with the post Day Care Center where childcare could be purchased from the Center. MACH could also convert a portion of a ward to a day care setting and either pay the center for services provided or employ a provider directly. Similarly, the hospital should consider some type of sick childcare which would allow parents to still work (maintaining

readiness) and have peace of mind that their sick child is being well cared for. This would need to be separate from the well childcare and have medical personnel staffing it.

- Family members and friends are less satisfied with the overall inpatient stay, nursing care, and physician's care in hospitals than are patients themselves. To the extent that patients' families or friends are themselves potential patients or are chief influencers of patients' health care choices, organizations that fail to satisfy this group of consumers risk the loss of future business (Strasser and Schweikhart, 1995). To combat this, the staff of MACH should be cognizant of this and actively address friends and families needs, as well as the patients.
- Reducing utilization is vital to the success of TRICARE. Frequent users of health care services should be identified and special training sessions conducted for them. Upon further review, it may be determined that case management services may be required.
- Incorporate a focus group which consists of young beneficiaries. Companies are already bringing in younger folks to help them design products and improve processes, as they see them as future customers. If you're working to create breakthrough products for the 21st century, why not work with the people who

live there already? (Weil, 1997). These folks do not have the bias or as many past experiences as do older more traditional customers and may provide a breath of fresh air.

- With schools located on the post, MACH should consider performing an outreach type of program for school children. Providers could revert to the "black bag" concept and have a sick call for children held at the school prior to the start of school each day. This would be an exceptional convenience for parents, which could enhance mission readiness. Simple cases could be treated and cleared to go to school; complex cases could be referred to the MTF for further treatment; or parents could be advised the child should not attend school that day.

Closing Comments

Integrated delivery systems (IDS) face the following marketing challenges:

- creating key audience "value" for the IDS
- creating and keeping a common brand strategy among the elements
- internal communications and cohesiveness (Marlowe, 1997)

For MACH and TRICARE to be successful, these issues will have to be addressed. The hospital must be up to the challenge, as our beneficiaries and our ultimate customer, the American people, will accept no less.

ACRONYM GLOSSARY

ACHE - American College of Healthcare Executives

AD - Active Duty

ADFM - Active Duty Family Member

AHA - American Hospital Association

AOL - America Online

CBO - Congressional Budget Office

CHAMPUS - Civilian Heath and Medical Program of the Uniformed Services

CSD - Clinical Support Division

DCP - Data Collection Period

DDEAMC - Dwight David Eisenhower Army Medical Center

Dep - Dependents

DH - Doctors Hospital

DHP - Defense Health Program

DOD - Department of Defense

FEHBP - Federal Employees Health Benefits Program

FY - Fiscal Year

GAO - General Accounting Office

HA - Health Affairs (see OASD-HA)

HMO - Health Maintenance Organization

HQ - Headquarters

HSMH - Hughston Sports Medicine Hospital

HSR - Health Services Region

IDS - Integrated Delivery System

IMD - Information Management Division

JCAHO - Joint Commission on Accreditation of Healthcare Organizations

MACH - Martin Army Community Hospital

MCFAS - Managed Care Forecasting and Analysis System

MCO - Managed Care Organization

MCSC - Managed Care Support Contractor

MHS - Military Health System

MTF - Military Treatment Facility

O & M - Operations and Maintenance

OASD-FM&P - Office of the Assistant Secretary of Defense for Force Management and Policy

OASD-HA - Office of the Assistant Secretary of Defense for Health Affairs

OASD-PA - Office of the Assistant Secretary of Defense for Public Affairs

OCHAMPUS - Office of the Civilian Health and Medical Program for the Uniformed Services

PA - Physician Assistant

PCM - Primary Care Manager

PCP - Primary Care Provider

POS -Point of Service

PPO- Preferred Provider Organization

SERMC - Southeast Regional Medical Command

SF - Saint Francis Hospital

SWOT - Strengths, Weak-nesses, Opportunities, and Threats

TMC - The Medical Center

TMO - TRICARE Marketing Office

TRADOC - Training and Doctrine Command

UM - Utilization Management

USAF - United States Air Force

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